13538

DATE 12/24/58 anthon & Xhans

ATE	23331 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Reg. Dist. No.	
	1. PLACE OF DEATH O. COUNTY Carroll 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a STATE Maryland b. COUNTY Balto.Ci.	
7	b. CITY OR TOWN (If outside corporate limits, write RURAL and give neo- sed give nearest lawn) c. CITY OR TOWN (If outside corporate limits, write RURAL and give neo Sykesville (Rural) 3yrs.7mos.23days Baltimore	rest town)
5	Saminaria I d Chata Hamata 7	ON A FARM? YES NO
	3. NAME OF DECEASED (Type of print) First Middle Lost Anderson Day Death December 22,	Year 19 58
	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED S. DATE OF BIRTH Female White WIDOWED DIVORCED January 27, 1893 9. AGE (in years left birthday) 65 yrs. Months Days F	UNDER 24 HRS.
	10a. USUAL OCCUPATION (Give kind of work done of the kind of work done of the kind of working life, even if relired) Packing House Employee Unknown Maryland 12. CITIZEN OF V U.S.A.	
)	13. FATHER'S NAME Stanislaus Krygier Louis Krager 14. MOTHER'S MADEN NAME Josephine Pilachowsk	i
	15. WAS DECEASED EVER IN U. S. ARMED FORCES? You no. or withnown If yes, give wor or dotes of service) No	
	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Acute myocardial infarction with perforation of Union	L BETWEEN AND DEATH LOWIL
	Conditions, if ony, which gave fire to immediate cause (b) Generalized arteriosclerosis. Year	28
	[0], storing the underlying DUE TO couse lost. (c). PART II. QTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(0) 19.	
2	Scalzophrenic reaction, paranoid type.	MEREORMED?
	200. EXTERNAL CAUSE WAS PRIMARY Der CONTRIBUTING 206. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Fort I or Port II of item 18.) CAUSE OF DEATH.	
	20c. TIME OF INJURY Manih, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.) While Not while of work of work of work	(State)
	21. I certify that I took charge of the remains described above, held an Autopsy . Inspection Inquiry opinion death resulted from: Natural causes . Accident . Suidide . Homicide . Undetermined manner	and in my
2	ACTUAL SIGNATURE ASSISTANT MEDICAL EXAMINER DECEMBER EXAMINER'S NAME-Type) James T. Marsh, M.D. DEPUTY MEDICAL EXAMINER DECEMBER December	
	220. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) REMOVAL (Specify) 12/26/58 St. Stanislaus Gemetery 1300 Dundalk Ave, Balto,	(Stote) Md.
	23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 240. REC'D BY, REGISTRAR 246. REGISTRAR'S SIGNATURE DATE /2/24/58 P. DATE /2/24/58 P	01.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please VS. A15ME 5M 2/57

THE DAY OF STREET WAS A STREET Secretary and the second secretary and the second s The second of th will be to appropriate the ending The Print Print Print 2 server below the

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

. IS RESIDENCE ON A FARM?

INTERVAL BETWEEN

PERFORMED?

YES NO

(Stole)

DATE SIGNED

(Stote)

vears

Days

U.S.A.

(County)

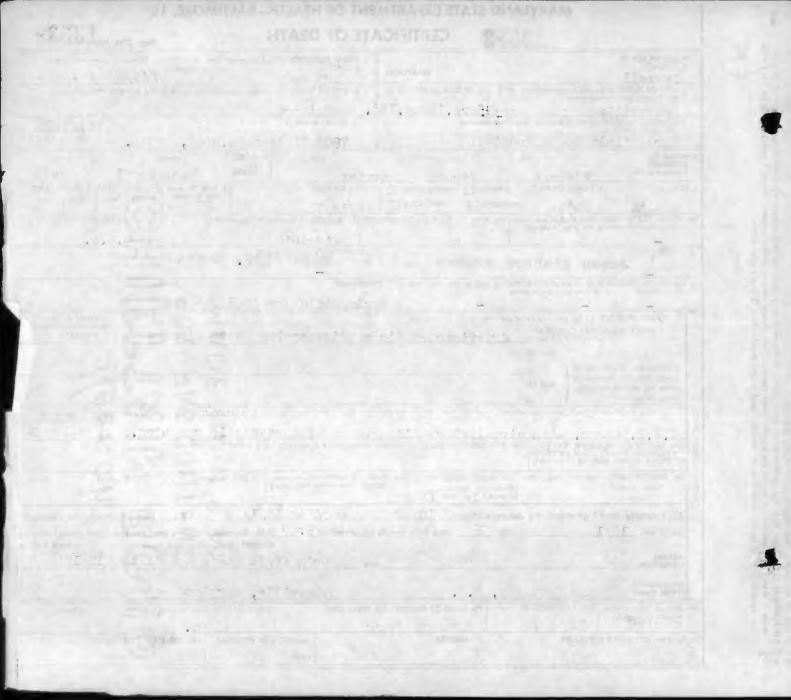
YES | NO |

Year

1958

death certificate 15M 9/SS

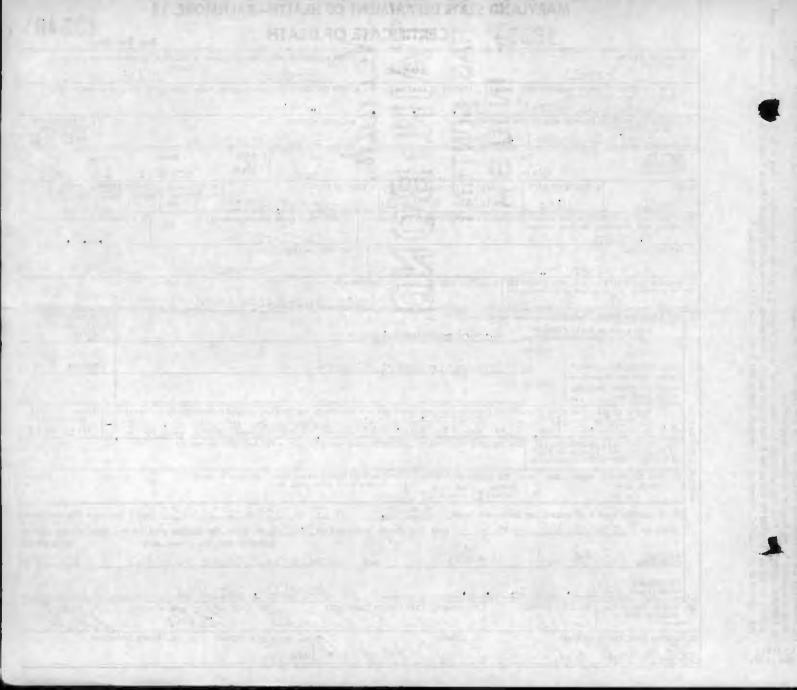
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15M 10/57

	-	11
in 24 hours ofter deoth: Page 4	filled in by the prot director, ges 1 and 2 show be filed with	F 1917
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours ofter death. Page 4	may be retained by the hospital or ottending physician. TO FUNERAL DIRECT: After this certificate has been signed by the attending physician and completely filled in by the profit director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cramation, or removal, and in any event within 72 hours after death.	
G PHYSICIAN: The low requires that	may be retained by the hospitol or attending physicion. O FUNERAL DIRECTA: After this certificate has been signed by the attending physician and comp page 3 should be detached for use as the burial-transit permit. Then please remove carbon pape the registrar prior to burial, cramation, or ramoval, and in any event within 72 hours after death.	
TO HOSPITAL OR ATTENDING	may be retained by the hosp TO FUNERAL DIRECT: After page 3 should be detached f the registrar prior to burial,	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 13540 **CERTIFICATE OF DEATH** 13553 Reg. Dist. No 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. COUNTY b. COUNTY MARYLAND Carroll Raltimore Marvland b. CITY OR TOWN (if outside corporate limits, write C. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) Sykesville Rural Baltimore d. NAME OF HOSPITAL (If not in hospital, give street oddress) d. STREET ADDRESS e. IS RESIDENCE OR INSTITUTION Springfield State Hospital 2002 Swansea Road YES NO TO NAME OF 4. DATE First Middle Month Day Year DECEASED (Type or print) Antcinett DEATH 1958 December Mary Beck 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED T NEVER MARRIED ET B. DATE OF BIRTH 9. AGE (In years lost birthday) Months Davi Hours DIVORCED T WIDOWED | Female White February yes 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPIACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) U.S.A. Unknown Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME John Beck Unknown 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address Springfield State Hospital Record 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia days **DUE TO** Rheumatic heart disease Conditions, if ony, which vears gave rise to immediate DUE TO couse (a), stating the underlying cause last. // 4 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19, WAS AUTOPSY CERTIFICATION Chronic brain syndrome associated with disturbance of growth, metab-PERFORMED? With senile brain disease, with psychotic reaction 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I of Part II of iden 18.) YES NO 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stole) foctory, street, office bldg., etc.) Hour o. m. While Not while of work of work 19 57, to December 10, 19 58 that I last saw the deceased 21. I certify that I attended the deceased from July 1 alive an December and that death accurred at 7:25 A.M. from the causes and an the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Rita S. Glahn, M. D. TO. BURIAL, CREMATION, 226. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d LOCATION (City, topic of county) (State) REMOVAL (Specify) 23, FUNDRAL DIRECTOR'S SIGNATURE ADDRESS 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Onthur & House



VS. A15ME 5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

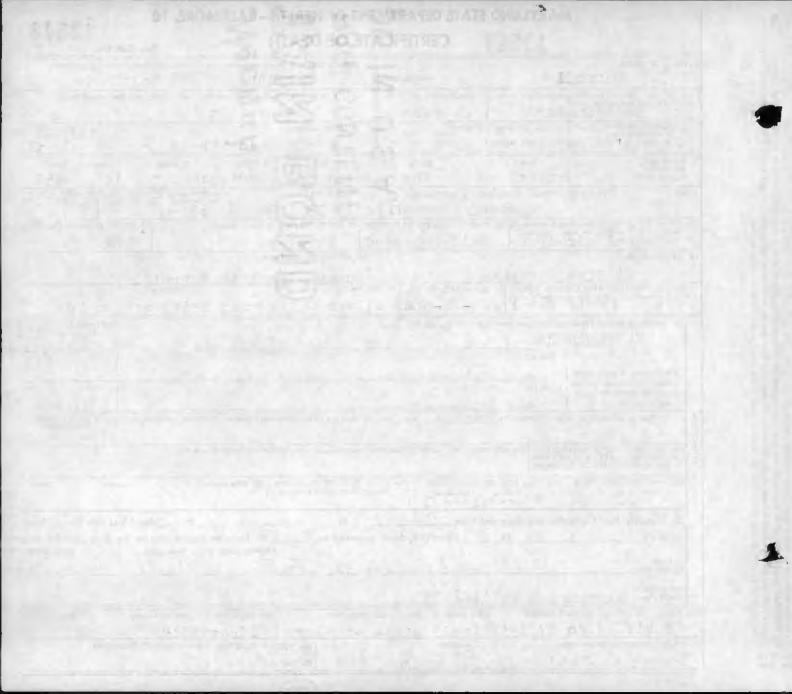
13541

	70003	Reg, Dist, No.
1.	PLACE OF DEATH o. COUNTY ARYLAND MARYLAND	2. USUAL RESIDENCE (Where deceased lived. It institution: Residence before odmission), o. STATE / ARYBAY b. COUNTY / PEGERICK
1	b CITY OR TOWN (If outside corporate limits, write RUPAL ond give reports town) + 1 A 1 R 4	C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pt-144 + 40	d. STREET ADDRESS ON A FARMY YES \(\) NO \(\)
3.	NAME OF DECEASED (Type or print) TAMES HERRE	Loal 4. DATE Month Doy Year OF DEATH DOR 13 1958
1	SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED MALE COLOREY WIDOWED DIVORCED	8. DATE OF BIRTH 1-18-1932 9. AGE (In year) Funder 1/EAR IF UNDER 24 HRS. Months Doys Hours Min.
	Bo. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUS during most of working life, even if refired to the property of th	MARYIANd. U.S.
1:	JAMES Otis Bell	Mildred Fredericks
10	Yes on an unknownth to the way of the way of anything to	ARYARET E. Bell-SAME
	18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c).] PART I. DEATH WAS CAUSED BY: SIGN DUE TO Conditions, if any, which gove rise to immediate cause (o), stoling the underlying cause last. DUE TO (c).	re-Skull-brushing mi
CEPTICICATION	PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT	NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO
MEDICAL	20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLA 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLA 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLA 40	ACE OF INJURY (Home, form, 201. (City or town) (County) (Store) pory, street, office bldg., etc.) Refglirlle Carrel My
	21. 1 certify that I took charge of the remains described abording apinion death resulted from: Notural causes . Accident	
	EXAMINET'S SAMES T MARSH	M.D. CHIEF MEDICAL EXAMINER DATE SIGNED ASSISTANT MEDICAL EXAMINER 12/13/5
ļ	20. BURIAL CREMATION. 22b. DATE THEREOF 22c, NAME OF CEMETERY OF BREMOVAL (Specify) 12-16-58 ST PA	uls Della-Fred. Co. Md.
6	3. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks III Frederick	240. REC'D BY REGISTRAR 246. REGISTRAR'S SIGNATURE

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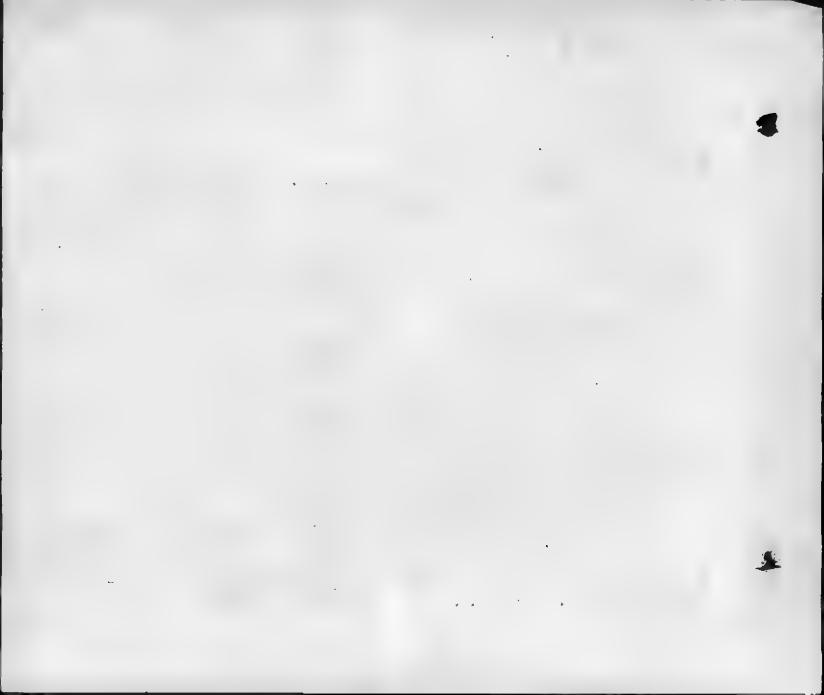
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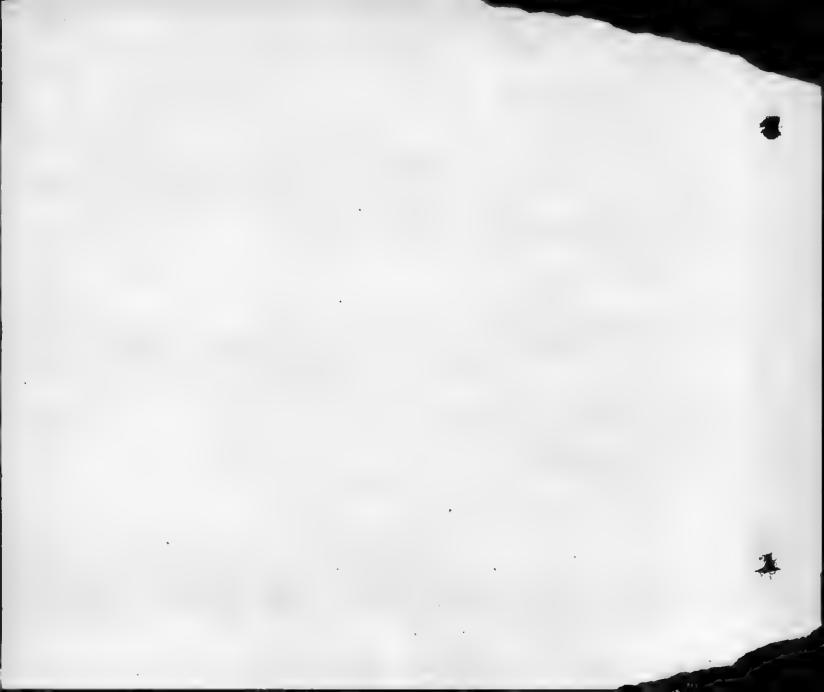
MAKTLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13555 **CERTIFICATE OF DEATH**

Reg. Dist. No. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institutions Residence before admission) o. COUNTY g. STATI b. COUNTY MARYLAND b CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest lown) RURAL and give nearest town) WEEK d. NAME OF HOSPITAL (If not in hospital, give street address) e. IS RESIDENCE OR INSTITUTION ON A FARM? YES TO NO TO NAME OF First Middle 4. DATE Month Year **DECE ASED** OF DEATH DEC (Type or print) 195 5 SEX 9. AGE (In years lost birthday) 7. MARRIED NEVER MARRIED IF UNDER I YEAR IF UNDER 24 HRS Months WIDOWED A DIVORCED | 100. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME WAS DECEASED EVER IN U. S. ARMED FORCES? INFORMAN CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o **DUE TO** Conditions, if any, which gove rise to immediate **DUE TO** cause (a), stating the underlying couse lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO IZ 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Part II of item 18) 20e. PLACE OF INJURY (Home, form, 20f. (City or town) 20c. TIME OF INJURY Month. 20d. INJURY OCCURRED Doy, Year (County) (Stale) factory, street, office bidg., etc.) Hour o.m. White Nat while of work of work p. m 21. I certify that I attended the deceased from whot I lost saw the deceased olive on ZAPM, from the causes and on the date stated above. ADDRESS (Street, city or lown, stote) ACTUAL PHYSICIAN'S NAME (Type) 22b. DATE THEREOF 220. BURIAL CREMATION. 22d LOCATION (City, town, or county) (Stote) REMOYAL (Specify) 23. FUNERAL DIRECTOR'S SIGNATORE **ADDRESS** 24b REGISTRAR'S SIGNATURE 24g, REC'D BY REGISTRAR

DATESEC

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13545 Reg. Dist. No.

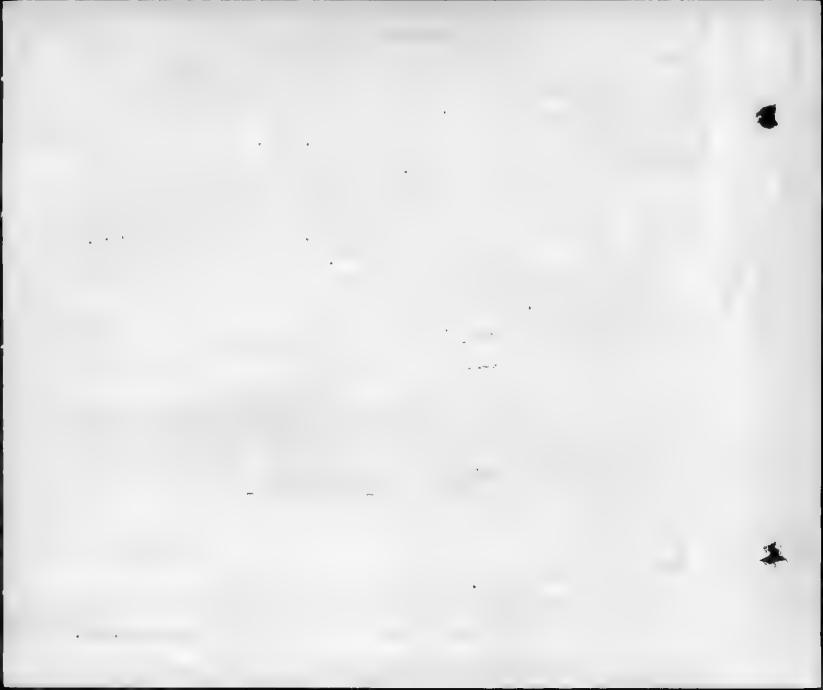
1. PLACE OF DEATH o. COUNTY			M	ARYLAND	2 USUAL RESI o. STATE Mai	DENCE (W	here decease	d lived If institut b. COUNTY		ce befor	e admiss	ion)
b. CITY OR TOWN (IF	outude corporate limi	N. write	c. LENGTH OF ST					rate limits, write I	DIPAt and		reast tour	2
RURAL and give ne	arest town)				H	·	'	rore limits, write i	D .	give nec	,)	"
Rural) Syke:				/days	d. STREET A		e, 11		Y	·	e IS RES	TOTAL
OR INSTITUTION							TF C+				ON A	FARM?
Springfield State Hospital 920 W. 38th. Street								YES [NO 29			
DECEASED	DECEASED						Do		Yeor			
(Type or print)	Dav			homas	Bow		DEATH	12	· · · · · · · · · · · · · · · · · · ·	30		19 58
5 SEX		7 MARI	RIED 🔼 NEVER MAI		B. DATE OF BIRT	DATE OF BIRTH 9. AGE (In years lift UND has birthday) Month				Doys	Hours	ER 24 HRS
Male	White	WIDOW	ED DIVOR	RCED 🔲	5-5-1	895		63 yrs	iviginity.	Days	HOUR	POTEL,
10o USUAL OCCUPATIO	N (Give kind of work ing life, even if retired	done 10b.	KIND OF BUSINES	S OR INDU	STRY 11. BIRTHPI	LACE (Stole	or foreign c	ountry)				COUNTRY
Watchm		' -			Mas	5.			U	.S.	1	
13. FATHER'S NAME					14 MOTHER'S	MAIDEN	NAME					
Ezra	Bowden				An	nie C	ristie					
15. WAS DECEASED EVER	IN U. S. ARMED FOR	CES? 16.	SOCIAL SECURITY	NO 17.	INFORMANT			Ado	lress.			
(Yes, no. or unknown) (I	1st W.W.	ervice)	027-05-21	66 :	Records	Sprin	gfield	State F	lospit	al		
18. CAUSE OF DEAT	TH [Enter only one co										RVAL BE	
PART I. DEA1	TH WAS CAUSED BY: IMMEDIATE CAUSE (o	Abs	cess in]	Left]	lung					Ora	feek?	BUEATH
52/x	DUE TO	-										
Conditions, if on	v. which)	Bro	ncopneumo	mia-k	ilatera?	1					lays	
gave rise to in	mediate (Dus To		THO DIVE WITE	/11454	JEZU OUZ U.			·		-		
cause (a), stating t tying couse last, j	ne under- [
			ONTR BUTING TO	DEATH BUT	NOT RELATED TO	THE TERM	INAL DISEAS	E CONDITION GL	VEN IN PAR	T 1(o) 1	9 WAS	AUTOPSY
	ersignificant con brain syn								9		PERSE YES	RMED?
	EUNDERLYING BY T	98 3PS	eleros is	. Wit	h psycho	tic r	Port Lor Port	t il of item 18.1			1123	
200. ACCIDENT WX	CAUSE OF DEATH			0000	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	(0.)						
	Month, Day, Yes	- lond 11	NJURY OCCURRED	20- 01	ACE OF INJURY (Mana Jan	204 (67)					
Y 20c. TIME OF INJURY	•	While	Not while	fo	ctory, street, office	e bldg., en	c.)	orlownj	((County)		(State)
	19		k al work									
21. I certify the	at I attended the	deceas	ed from 9-	11	, 19 <u>.58</u>	. to]	2-30	, 19.58	thot I	last so	w the	deceased
alive on_12=	30	_, 19_	582 and th	at death	occurred of	9:40	PM, from	n the causes	and on t	he doi	te state	ed obove
	WITT	A	non	1.0				lreet, city or town				ATE SIGNED
ACTUAL	acces	10	000	ν_{I}	MD. S	pring	field	State Ho	spita	1		
To the same of the	alter Knop	m. M	D	7								
PHYSICIAN'S VI NAME (Type)	erect mob	P)	•	(S	vkesv	rille.	Maryland	1			
220. BURIAL, CREMATION	, 226. DATE THEREC	F	22c. NAME OF C	EMETERY O		•		IION (City, town,			(Slot	e)
REMOVAL (Specify)	Jan 3 1	050	Cedar	H4 7 7				hie Hi	* /	4	E a	
23. FUNERAL DIRECTOR'S		204	ADDRESS			240. REC	D BY REGIST	RAR 24b. REG	STRAR'S SI	NATÚ	d.	
Tusten	16 Don	ova	W-3818	Prot	and lew	DATE	JAN 5	28	كم الممال بياس	A 1 (1)		

may be reliained by the hospital or ottending physician.

O FUNERAL DIRG 201: After this certificate has been signed by the ottending physician and completely filled in by the page 3 should be accorded for use as the burial-transit permit. Then please remave carbon papers. Pages 1 and 2 stather registror prior to burial, cremation, or remayal, and in any event within 72 he/us ofter death. TO FUNERAL DIRE
Poge 3 should be TO HOSPITAL OR VS A15 (4) 15M 10/57

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

factor director, be filed with



VS A15 (4) 15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13557 CERTIFICATE OF DEATH

13546

Rea. Dist. No.

1. PLACE OF DEATH o. COUNTY CS	rroll		MAR	YLAND	2. USUAL RES o. STATE	idence (who	ere deceased	l lived. If insti b. COUN		nce before	admission)
b. CITY OR TOWN (RURAL and give a	If outside corporate limi	ls, write	c. LENGTH OF STA					rote limits, writ	e RURAL ond	give neare	est lown)
Wood	bine		11 M) •	Ba.	ltimo	re Ci	Lty	3	VO.	1-4
d. NAME OF HOSPI OR INSTITUTION	TAL (If not in hospital, g	ive street	oddress)		d STREET					e,	IS RESIDENCE
	Weitzel	Lur	sing Hor	ne.	131	J Ash	ury F	lond -			YES NO
3. NAME OF DECEASED (Type or print)	Josep		SHEITO	· ·	BREN!		4. DATE OF DEATH	_	Month 20	Day	Yeor 19 58
S. SEX	6. COLOR OR RACE	7. MARR	RIED NEVER MARR	IED 🔲	B. DATE OF BIRT	TH		9. AGE (In yes			UNDER 24 HRS
Male	White	WIDOW			Jan.28	3-189	1.	67	Y) Months	Days 1	Hours Min
UUTING MOSI OT WOL	ON (Give kind of work of king life, even if retired		KIND OF BUSINESS	OR INDU	STRY 11. BIRTHP	LACE (State o	or foreign co	wnfry)	12 CI	TIZEN OF	WHAT COUNTRY
Retired-	Signal ha	n	Penna.R.	R.	IId	i.				U.S.	Α -
13. FATHER'S NAME					14. MOTHER'S	MAIDEN N	AME			W V 100 - 0	
Joseph	Brenize				Jenn	nie Ba	ailev				
15. WAS DECEASED EVE	R IN U. S. ARMED FOR	ervice)	SOCIAL SECURITY N		NFORMANT				Address 72	161-	ore 9.1
(Yes no ey uninown)		7	17-07-62	260	Tellic	i. Sr	enize	-1315	asb	ury	- for-
	mmediate DUE TO		enliget	err 10	ent, a	rogh	is La	ters!	Sclero		AND DEATH 1,957 40 Dec 58
PART II. OT	HER SIGNIFICANT CON		ONTRIBUTING TO DI	FATH BUT							WAS AUTOPSY PERFORMED? (ES NO NO
	S UNDERLYING [] CAUSE OF DEATH MEDICAL EXAMINER]		CRISE HOW INJURY (OCCURRE	D. (Enter nature o	of injury in Po	ort I or Part	If of item 18.)			
3 20c. TIME OF INJUI Hour e. m. p. m.	Y Month, Day, Yea	While of work	NJURY OCCURRED Not while	20e. PL/ fac	ACE OF INJURY tory, street, offic	e bldg., etc.)				(County)	(State)
21. I certify the olive on	Sovard	decease , 19 3		191 death	occurred of	8:30	_M, from	the couse	s ond on t	last sow the date	the deceased stated obove DATE SIGNED DATE 1 &
220. BURIAL, CREMATIC		F	22c. NAME OF CEM	AETERY OF	- energy and a		22d LOCAT	ION (GityLear	nume county)		(Stote)
REMOVAL (Specify)	てのような中に	58	Jessops	Tot	hodist.						24.7
23. FUNERAL DIRECTOR			ADDRESS				BY REGISTS		GISTRAR'S SI	GNATURE	
Frank "	. Seitz 8	314	30th.	St.		DATENEO	2 ∠ 58				
						1 1 1 1 4				400	



VS A15 (4) 15M 10/57 15

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MARYLAND	STATE	DEPARTMENT	OF	HEALTH-BALTIMORE,	18

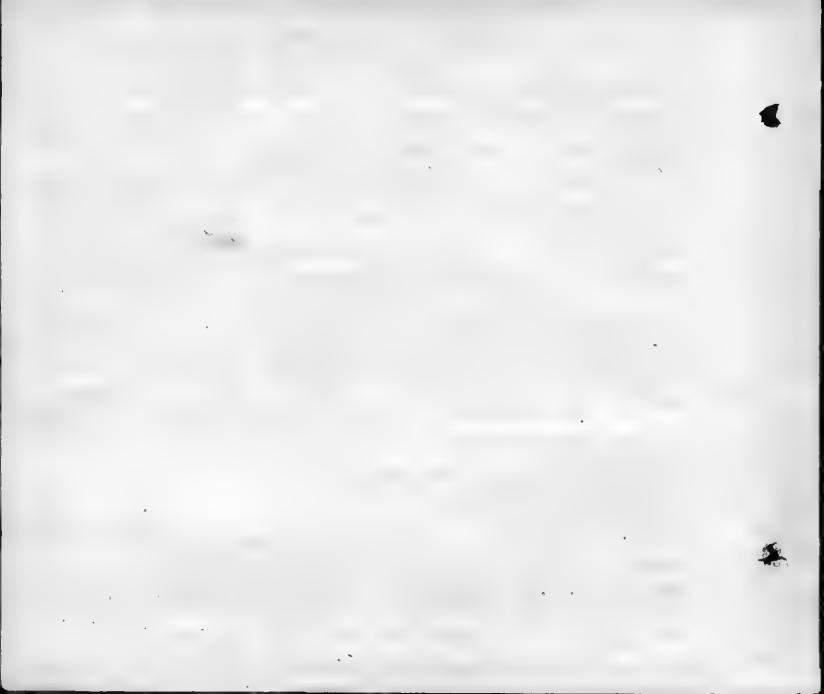
13558 CERTIFICATE OF DEATH

13547

			Keg. Dist. No.
1. PLACE OF DEATH 0. COUNTY AND AND CARROLL	MARYLAND	2. USUAL RESIDENCE (Who o. STATE Maryland	ere deceased lived. If institution: Residence before admission) b COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (If o	utside corporate limits, write RURAL and give nearest tawn)
Sykesville	19 mos	Baltimor	e City 2VV
d. NAME OF HOSPITAL (If not in hospital, give street or INSTITUTION	address)	d. STREET ADDRESS	e. IS RESIDENCE ON A FARM?
Springfield State Ho	spital	337 S. B	entalou Street VES NOTE
3. NAME OF First DECEASED (Type or print) Edward E. Broo	Middle K8	Lest	4. DATE Month Day Yeor DEATH December 27 1958
5. SEX 6. COLOR OR RACE 7 MARR	IED NEVER MARRIED	8 DATE OF BIRTH	9 AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS
Male White WIDOWE	D IVORCED	12-30-1896	61 yrs. Months Days Hours Min,
10s USUAL OCCUPATION (Give kind of work done 10b. during most of working life, even if retired)	KIND OF BUSINESS OR INDU	STRY 11. BIRTHPLACE (State	or foreign country) 12. CITIZEN OF WHAT COUNTRY
Crain Hooker Crow	n Cork & Se	al Baltimor	e Maryland USA
13. FATHER'S NAME		14. MOTHER'S MAIDEN N	
Robert M. Brooks		Clara W.	Ball
15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16 (Yes, no or unknown) (If yes, give wor or dates of service)	SOCIAL SECURITY NO 17.	INFORMANT	Address
	3-01-5363 A	uthur O.God	man-337 S. Bentalou Street
18. CAUSE OF DEATH [Enler only one couse per lin			INTERVAL BETWEEN
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)	Linonelera	To carail	ONSET AND DEATH
4221 DUE TO			
Conditions, if ony, which) (b)			
gove rise to immediate couse (o), stoling the under-			
lying couse lost.			
PAIT II. OTHER SIGNIFICANT CONDITIONS C	ONTRIBUTING TO DEATH BUT	NOT RELATED TO THE TERMIN	NAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED?
3 Crangeligeoma of	lenings.	syskeht a	ephisorie reaction yes NO N
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTIONS CONCENTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 of world worl	CRIBE HOW INJURY OCCURRE	D (Enter noture of injury in P	ort I or Port II of item 18.)
3 20c. TIME OF INJURY Month, Day, Year 20d. IN	JURY OCCURRED 20e PL	ACE OF INJURY (Home, form,	20f (City or Iown) (County) (Slate)
Hour o.m. While of work	Not while to	ctory, street, office bldg., etc.	
21. I certify that I attended the decease	d from T-2 -	2 10.57- /	7-27 10 7
alive on \$2-26 19	- 0		2 19 Sthat I last saw the deceased
dilve oil	1.9L., and that death	accurred a darly	ADDRESS/(Street, city or town, state) DATE SIGNEY
ACTUAL WALLS KU	when	MD. Jorga	upield State Masjirtal
PHYSICIAN'S WALTER	KNOTOP	Syke	Isville, 14D 12-27-50
220. BURIAL, CREMATION, 226. DATE THEREOF	22c. NAME OF CEMETERY O	R CREMATORY	22d. LOCATION (City, town, or county) (Stote)
Burial Dec. 31-58	Loudon Par	k Cemetery	Baltimore Maryland
23. FLINERAL DIPECTOR'S SIGNATURE	ADDRESS		BY REGISTRAR 24b. REGISTRAR'S SIGNATURE
T. D. Wickert	-1300 Eutaw	PI DAREC	2 9 58 arthur S. Kraus



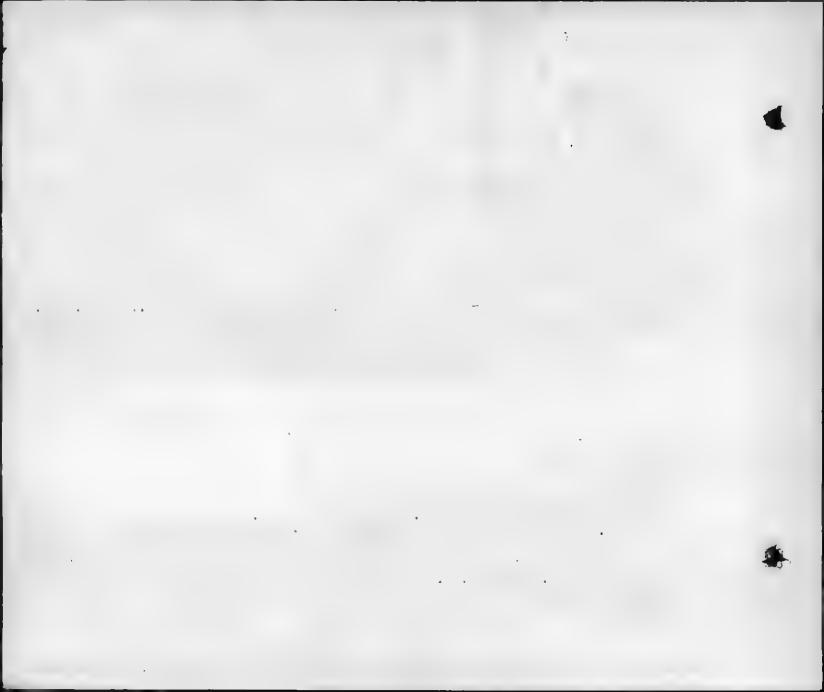
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 13548 13549 **CERTIFICATE OF DEATH** Reg. Dist. No 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. COUNTY 46. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) RURAL and give negrest lawn) d NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE OR INSTITUTION ON A FARM? YES TI NO P 3. NAME OF 4. DATE fied Middle Lost Month Day Year DECEASED (Type or print) 2.5 Brown DEATH 19 5. SEX 6. COLOR OR RACE 9. AGE (In years lost birthday) IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED TI NEVER MARRIED TI B. DATE OF BIRTH Months Days WIDOWED [7] DIVORCED | 100. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retifed) 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16, SOCIAL SECURITY NO. 17. INFORMANT Address 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gove rise to immediate **DUE TO** cause (a), stating the underlying couse last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO 1 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Port II of item 18.) 20c. TIME OF INJURY Month, Day. Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (State) Haur a. n. factory, street, affice bldg., etc.) While Not while of work at wark p. m. 21. I certify that I attended the deceased from 19____that I last saw the deceased and that death accurred at I I I M, fram the causes and an the date stated above. ADDRESS (Street, city or lown, state) DATE SIGNED ACTUAL SIGNATURE P THE RESERVE M. E. Robertson New Windsor. NAME (Type) 220. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, Ipwn, or county) (Stote) page REMOVAL (Specify) 10 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS. 24b. REGISTRAR'S SIGNATURE 240. REC'D BY REGISTRAR DAREC VS A15 (4) 15M 9/55 C. W. S. Franks





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH 13560 Rea. Dist. No. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) o. COUNTY b. COUNTY MARYLAND b. CITY OR TOWN Iff outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) d. NAME OF HOSPITAL (If not impospital, give street address) J. STREET ADDRESS e. IS RESIDENCE OR INSTITUTION ON A FARM? 11 YES I NO IN NAME OF 4. DATE Middle Month Day Year DECEASED (Type or print) DEATH 195 6. COLOR OR RACE 7. MARRIED T NEVER MARRIED T 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS DATE OF BIRTH lost birthdayl Months Days WIDOWED PL DIVORCED | USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stote or foreign country) during most of working life, even if retired) 12. CITIZEN OF WHAT COUNTRY? 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16/80CIAL SECURITY NO. 17. INFORMAN Address 18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED 8Y IMMEDIATE CAUSE (o) **DUE TO** Conditions, if any, which gove rise to immediate **DUE TO** cottse (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY PERFORMED? YES INO NO 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Doy. 20d. INJURY OCCURRED 20e, PLACE OF INJURY IHome, form, Year 20f. (City or town) (County) (Stote) foctory, street, office bldg., etc.) o. m. While Not while lot work T at work P. m. 21. I certify that I attended the deceased from 19 J. Othat I last sow the deceased olive on__/ and that death occurred ot_____M, from the couses and on the date stated above. ADDRESS (Street, city or town, stote) DATE SIGNED ACTUAL SIGNATURE PHYSICIANS NAME (Type) 220. BURHAL CREMATION. 22d. LOCATION (City, town, or county) 22c. NAME OF CEMETERY OR CREMATORY (Stote) REMOVAL (Specify) FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** 24a. JEC'D 8Y REGISTRAR 24b. REGISTRAR'S SIGNATURE Cirthur S. First DATE DEC 3 0 '58 15M 9/55





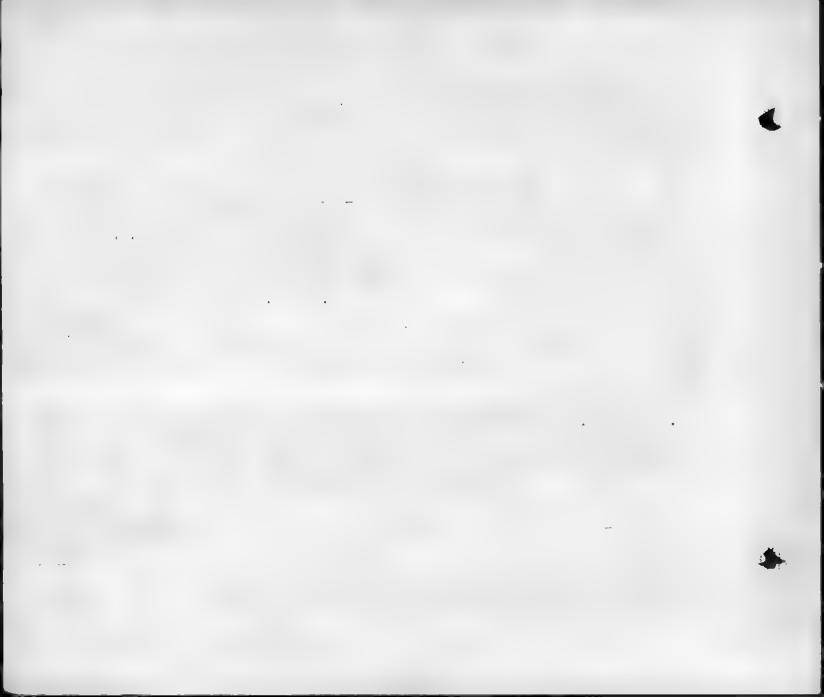


13563	CERTIFICATE	OF	DEA 1	ſΗ

R	eg.	Dist.	No.	
Ü2		dence	before	odm

スクシハウ					Keg. Dist.	. No.	
1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. COUNTY a. STATE							
Carroll	RYLAND	Maryland	1	b. COUNTY	Wicon	nico	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	AY IN 16	c. CITY OR TOWN (If aut	tside carpor	rate limits, write R	URAL and giv	re nearest town) /	
Sykesville 16 day	78	Bivalve			A. R.	*	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS				1S RESIDENCE ON A FARM?	
Springfield State Hospital						YES NO 💢	
3. NAME OF First Mide DECEASED	dle	Losi	4. DATE OF	Man	th	Day Year	
(Type or print) Ara Eliza		Chabara	DEATH	12		14 19 58	
5. SEX 6. COLOR OR RACE 7. MARRIED A NEVER MAR	RRIED 🔲 B.	DATE OF BIRTH		9. AGE (In years last-buthday)		YEAR IF UNDER 24 HRS.	
F W WIDOWED DIVOR	CED [2-26-76		82 yn.	Months D	Agys Heurs Min.	
10g USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS	OR INDUST	RY 11 BIRTHPLACE (State of	r fareign co	untry)	12. CITIZ	EN OF WHAT COUNTRY?	
during most of working life, even if retired) Housewife		Maryland	3		U.S.	.A.	
73. FATHER'S NAME		14 MOTHER'S MAIDEN NA	WE				
Sylvester Shockley		Martha Er	nglish	2			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY N	NO. 17. INF	ORMANT		Add	/e11		
(Yes, no. or unknown) (If yes, give war or dates of service) unkn	Sp	oringf.Hospit.	. Red	ords			
III. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (INTERVAL BETWEEN	
PART I. DEATH WAS CAUSED BY: Arteriosclero	otic ca	rdiovascular	disea	ase		vears	
4 d. d. l DUE TO						1000	
Conditions, if ony, which) (b) Generalized	arteri	osclerosis				vears	
gave rise to immediate						YVQID	
lying cause last							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO	DEATH BUT N	OT RELATED TO THE TERMIN	AL DISEASE	CONDITION GIV	EN IN PART	I(a) 19 WAS AUTOPSY	
C.B.S. assoc. with cerebral arte	ioscle	rosis, Moder. s	advano	ced activ	re TB	PERFORMED?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO E C.B.S. BASOC. With cerebral arte 200. ACCIDENT WAS UNDERLYING CONCONTRIBUTING CAUSE OF DEATH OF CONTRIBUTING CAUSE OF DEATH OF CONTRIBUTING CAUSE OF DEATH OF CONTRIBUTING TO EXAMPLE TO THE CONTRIBUTION OF	OCCURRED	(Enter nature of injury in Pa	itt I ar Part	11 of item 18)			
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED	20e PLAC	E OF INJURY (Home, farm,	20f (City	or town)	íCo	unty) (State)	
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED Hour 6. m. 19 While Not while at work at work	facto	ry, street, affice bldg., etc.)			,	(2.2.1)	
21. I certify that I attended the deceased from.	11-28	, 19 <u>58</u> , ta	12-	13 -19 58	that I la	st saw the deceased	
720 70		occurred at 7: A					
				reel, city ar town,		DATE SIGNED	
SIGNATURE Church Jus Warmen, Springfield State Hospital 12-14-58							
PHYSICIAN'S							
NAME (Type) Edmidn Lusthaus M.D.		Sykesville	Mory	land			
220. BURIAL, CREMATION, 226. DATE THEREOF 22c NAME OF CE PROVAL (Specific) 12758 BID 2/	EMETERY OF			ION (City, tawn, o	or county)	(State)	
23. EUNERAL DIRECTOR'S SIGNATURE ADDRESS /	1	24g. REC'D	BY REGISTI	RAR 24b, REGIS	STRAR'S SIGN	LATURE	
The Monito (Ringala	2,9	d, DATE DEC			then 8. 1		
- War I was a second		A PART DEC					

VS A15 (4) 15M 9/55



13564

CERTIFICATE OF DEATH

13554

"L										_ R	eg. Dist	. No.		
	PLACE OF DEATH	rroll		MARYLAND	2	USUAL RESIDENCE STATE	e (Whe		lived, If instit b. COUN		Pesidence I nkno		odmiss	ion)
	b. CITY OR TOWN (III RURAL ond give ne Sykesville		ts, write	Liyre. 9mth160	iys	c. CITY OR TOWN		otside corpor		RURA	L ond go	re near	est town)
	OR INSTITUTION	AL (If not in hospitol, g		-		3703 Be		r Rd.				•		DENCE FARM? NO (3)
	NAME OF DECEASED (Type or print)	Georg	e	Henry		Chaney	7	4. DATE OF DEATH	1	2 th		19		19 ⁵⁸
	Male Male	White	WIDOWE		5	9-18- 92	_		9. AGE (In year lost birthday) M	UNDER 1	YEAR	Hours	R 24 HRS. Min
Вс	Zer	N (Give kind of work on the line of the li	iane 10b.	KIND OF BUSINESS OR IND	USTRY	11. BIRTHPLACE Mary Le		or foreign co	ountry)		U.S.	_	TAHW	COUNTRY
13.	FATHER'S NAME				14	MOTHER'S MAI								
L		ge W.Chane				Anasta	atis	ı Cu	mingt					
15.	n, no. or unknown)	R IN U. S. ARMED FOR	CES? 16.	SOCIAL SECURITY NO. 17.	INFOI	RMANT Hos	spit	al re	cords.	ddress				
, NC	Conditions, if or gove rise to in couse (o), stoling the lying couse lost.	TH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Dy, which n mediate the under- (c)	sude a p	den death by a lece of meat	ir	n the the			E CONDITION (SIVEN	IN PART 1	Se	WAS A	DEATH
CERTIFICATION	Schizoph	renic reac	tion	paranoid type	≥•							(0)	PERFO YES A	NO
CERT	OR CONTRIBUTING	☐ CAUSE OF DEATH I				ner no ora or myo	.,		7 0 110.11					
MEDICAL	20c TIME OF INJURY Hour e. m. p. m.	Month, Doy, Yea	While	NJURY OCCURRED 20e. F	LACE (actory,	OF INJURY (Home street, affice bldg	, farm, 3., etc.)	20f. (City	or town)		(Co	unly)		(State)
	21. I certify the olive on	of I attended the	decease 12 021	ed fram, and that deat	h occ	Ukls	35 1	M, fram	the causes	and	an the			
22c	BURIAL CREMATION REMOVAL (Specify)	12/24/58	F	Parkwood C					ION (City, town				(Stote)
23 U	funeral director's	signature eral Home 4	1210	ADDRESS Belair Road.			- 33	BY REGIST		SISTRA	R'S SIGN	ATURE	ح پادی	

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 uneral director, id be filed with may be retained by the haspital ar attending physician.

TO FUNERAL DIGICTOR: After this certificate has been signed by the attending physician and campletely filled in by page 3 should tetrached far use as the burial-transit permit. Then please remove carban papers. Pages 1 and 2 the registrar prior to burial, crematian, ar removal, and in any event within 72 hours after death. TO HOSPITAL OR VS A15 (4) 15M 9/S5



VS A1S (4) 15M 10/S7

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13565

CERTIFICATE OF DEATH

	ð	J	G	

				keg. Dist.	No.	
1. PLACE OF DEATH o. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE b COUNTY					
Carroll	MARYLAND	Maryland Carroll				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn)				
Taneytown	1+ years	X Tanevtown				
d. NAME OF HOSPITAL (If not in hospital, give street OR INSTITUTION	oddress)	d. STREET ADDRESS			e IS RESIDENCE ON A FARM?	
		Broad S	treet		YES NO R	
3. NAME OF First	Middle	Losi	4. DATE	Month	Day Year	
DECEASED (Type or print) ROW	Cr	ollins	OF DEATH T	December 2	21. 19 58	
		DATE OF BIRTH		E (In years IF UNDER 11	EAR IF UNDER 24 HRS.	
Wale White WIDOW	24	law 1, 1917	lost	birthdoy) Months Di	ays Hours Min	
10a. USUAL OCCUPATION (Give kind of work done 10b.	KIND OF BUSINESS OR INDUST		or foreign country)		EN OF WHAT COUNTRY	
during most of working life, even if retired]	21 D	7733-3-		17	C 4	
Machine Operator Ru 13, FATHER'S NAME	bber Factory	Virginia			S.A.	
Abram Gollins 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16.	SOCIAL SECURITY NO. 17. IN	Ruthia	Gibson	Address		
(Yes no, or unknown) (If yes, give war or dates of service)						
18 CAUSE OF DEATH Enter only one cause per li		rs. Grace Col	lins, Tar	neytown, Md	1 - T - T - T - T - T - T - T - T - T -	
18 CAUSE OF DEATH [Enfer only one cause per li PART I. DEATH WAS CAUSED BY:	ne for (0), (0), and (c).]	1-			INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (o)	noucho	Jeneur	unce-	<	Zellanz	
DUE TO	7	1	_	11 .	1,07 10	
Conditions, if any, which by gove rise to immediate	myourpu	La Vizuez	zessive	Afecual	10 West:	
Couse (p), stoting the under-	J	/				
lying couse lost. (c)						
PART II OTHER SIGNIFICANT CONDITIONS	CONTRIBUTING TO DEATH BUT I	NOT RELATED TO THE TERMI	NAL DISEASE CONI	DITION GIVEN IN PART 1	(o) 19. WAS AUTOPSY PERFORMED?	
3 43; ×.					YES NO TH	
PART II OTHER SIGNIFICANT CONDITIONS (# 1 / / / 20a, ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	CRIBE HOW INJURY OCCURRED	. (Enter nature of injury in P	ort I or Part II of i	tem 18.)		
	NUIBY OCCUPED 200 PLA	CE OF INDIES (Name form	206 (01)	-1 10	40.11	
Hour o. m. While Not while foctory, street, office bldg., etc.)						
p, m, if of wor	k of work			mer and to		
21. I certify that I attended the deceas	-	, 19⊇ <u>8,</u> Ia./	721		st saw the deceased	
alive on 12/2/ 195	>_&, and that death	occurred of 2:30 f	M, fram the	causes and an the	date stated above.	
12 150	2011	in of	DORESS (Street, ci	ly or town, state	DATE SIGNED	
ACTUAL SIGNATURE	1º Vary	D. 44/ T/20	direct	27. 16cm	estone ma	
PHYSICIAN'S RAME (Type) R. S. M.	Vaugh				12/22/5	
220. BURIAL, CREMATION, 226. DATE THEREOF	22c. NAME OF CEMETERY OR	CREMATORY	22d. LOCATION (C	ity, town, or county)	(Stote)	
REMOVAL (Specify) Burial 12/26/58	Pleasant Pein	t Camatery	Tazekell	, Tennessee	,	
23. FUNERAL DIRECTOR'S SIGNATURE 77	ADDRESS		AY REGISTRAR	24b REGISTRAR'S SIGN	ATURE	
CO Fire & Son Tener	bown Marmiland	DATE	C 2 4 58		tand	



13566 CERTIFICATE OF DEATH

13556

		O O C	70					Key. D	131, 140.			
1. PLACE OF DEA o. COUNTY Gary			MARYL	AND	2. USUAL RESIDENCE (Who o. STATE Maryland		d lived If institution b. COUNTY	oni Reside	nce befor	e admission)		
	WN (If outside corporate limitative neares) town)	its, write	c. LENGTH OF STAY II	и 1ь	c. CITY OR TOWN (If or	ulside corpo	rata limits, write R	URAL ond	give nea	rest town)	V	
Henry			712 day	75	Baltimo	re	6	V : /				
	IOSPITAL (If not in hospital, o	ive street		<u> </u>	d. STREET ADDRESS				1	. IS RESIDENCE	E	
	on State Hosp	tal			611 Pit	cher S	Street			YES . NO		
3. NAME OF DECEASED	Fi	rst	Middle		Lost	th	Day	Year				
(Type or print)	Mat	rjori	e Jea	n	Coward	OF DEATH	ber 13, 19			ă		
S. SEX	6. COLOR OR RACE	7 MARI	LED NEVER MARRIED		B. DATE OF BIRTH		9. AGE (In years lost birthday)			IF UNDER 24 H		
Female	Negro	WIDOW	DIVORCED		12-15-31		23 уп.	Months	Days	Hours Min	n	
100. USUAL OCCL	JPATION (Give kind of work if working life, even if retired	dane 10b	KIND OF BUSINESS OR	INDUS	STRY 11 BIRTHPLACE (Stote	or foreign c	ountry)	12 CI	TIZEN O	F WHAT COUN	ITRY?	
None	working into, even in reinteo	,			North Car	rolina	Ĩ.		U.S.	Α.		
13. FATHER'S NAM	(E				14. MOTHER'S MAIDEN N	AME				*		
7err												
15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address [Yes, no or unincoun] [1] yes, give wer set dotat of service]												
No	er St	treet										
18. CAUSE O	F DEATH [Enler only one co	ouse par li	ne for (a), (b), and (c).]						INTE	RVAL BETWEEN	N	
PART	DEATH WAS CAUSED BY:	Far	advance bi	late	eral cavitary	pulme	onāry the		ONS	ET AND DEATI	Н	
002)	OO 2 X DUE TO											
Conditions	Conditions, if any, which) (b)											
gove rise	gave rise to immediate Outsta											
lying couse	gitting the nuger-											
_ 			ONTRIBUTING TO DEAT	TH BUT	NOT RELATED TO THE TERMIN	NAL DISEAS	E CONDITION GIV	EN IN PA	RT 1(o) 19	, WAS AUTOP	SY	
ATIO		_							, ,	PERFORMED?	?	
PART II 200 ACCIDEN OR CONTRIBL (IF EITHER, NO	NT WAS UNDERLYING	20b. DES	CRIBE HOW INJURY OC	CURREC). (Enter nature of injury in P	ari 1 ar Par	t II of item 18.)					
	JTING CAUSE OF DEATH OTIFY MEDICAL EXAMINER)											
G Hour	INJURY Manth, Day, Ye o. m. 19 p. m.	While	NJURY OCCURRED 2 Not while k at work	ioe. PLA fac	ACE OF INJURY (Home, form, dary, street, affice bldg., etc.	20f. (City	r or town)		(County)	(Slo	olej	
21. I certif	fy that Lattended the	deceas	ed from Janua	ry 3	21, 19.56, ta De	edembe	r 1319 5	Sthat 1	last sa	w the dece	osed	
alive an_±	December 113	, 19	58, and that	death	accurred at 2:15P	_M, fror	n the causes o	nd an	the dat	e stated ab	ave.	
	i: In M	7	1 //.	6			Ireel, city or lawn,			DATE SIG		
ACTUAL SIGNATURE_	10: 17: 177	2029	lace M.	1/	Henry	ton, 1	faryland		٦	2-13-59	3	
PHYSICIAN'S NAME (Type)	Dr. Edgars 1	1. Ma	culans, Sup	t.	Henryton St	tale ^r	losvital,	Hen	r,,thr	ı, lid.		
220. BURIAL, CREA REMOVAL (Sp	MATION, 226 DATE THERECO	1458	11/ Cul	ERY OF	CREMATORY Cervetera	22d LOCA	TION (City, town, o	or county)		(State)		
23. FUNERAL DIRE	CTOR'S SIGNATURE		ADDRESS			BY REGIST	TRAR 24b REGIS	TRAR'S S	GNATUR	E		
Good or	the Rus	-	2222 W	7	DUTE TO CE PATE /	2-16-0	SE Phit	Jus .	ad.	Krai	110	
							4					

TO MUSPITAL DIR TITIONING MHYSICIAN: The law majories that the death certificate be executed within 24 hours after death. Page I may be remined by the haspital or miterating majories.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should by prached far use as the burial-transit permit. Then please remaye carbon papers. Pages 1 and 2 strong be filed with the registrar priation burial, cremation, ar remayal, and in any event within 72 pours ofter death.

VS A15 (4) 15M 9/SS



VS ATS (4) TSM 9/55 M

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE,	18
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13567 CERTIFICATE OF DEATH

		<u></u>	201						Reg. Dist.	No
١.	1. PLACE OF DEATH 6. COUNTY					2. USUAL RESIDENCE (Who			Residence	before admission)
}	Carro	11		MARYL	UND	Maryland		b. COUNTY	Car	roll
	b. CITY OR TOWN (RURAL and give n	If outside corporate limi	ts, write	c. LENGTH OF STAY IN	County C		e nearest fown)			
	Sykesvi	lle		1 mon. 8 d	ays	X Union Br	idge.			
a de la constante de la consta	d. NAME OF HOSPI OR INSTITUTION	AL (If not in hospital, g	ive street	oddress)		d. STREET ADDRESS				. IS RESIDENCE
		eld State	Egsol	ital		209 Penro	se Stree	t		YES NO TO
	3. NAME OF DECEASED	For	st	Middle		Lost	4. DATE	Month		Doy Year
	(Type or print)	13)	DITH	SPAH	R	CRAMER	DEATH	Decemb	per 2	1958
	5. SEX	6. COLOR OR RACE	7. MARI	RIED NEVER MARRIED		. DATE OF BIRTH	9. AG	E (In years		
	Female	White	WOOW	ED DIVORCED		3-16-84	"7"		Months D	oys Hours Min.
	10a USUAL OCCUPATIO	ON (Give kind of work king life, even if retired	done 10b.	KIND OF BUSINESS OR	INDUS	TRY 11, BIRTHPLACE (Stole of	or foreign country)		12. CITIZE	EN OF WHAT COUNTRY
	Housewo		'			Marylan	d			U-S-A-
	13 FATHER'S NAME					14 MOTHER'S MAIDEN N	AME			
	·* Jo	hn William	Cran	ner		Rebecca	Elizabe	th Spat	יינ	
	15 WAS DECEASED EVE	R IN U. S. ARMED FOR		SOCIAL SECURITY NO	17. IN					
	No	fit has the new or more or a			1	Records, Spri	ngfield :	State F	lospit	al
	18. CAUSE OF DEA	ATH [Enter only one co	use per li	ine for (o), (b), and (c).]						INTERVAL BETWEEN
	PART I. DEA	TH WAS CAUSED BY. IMMEDIATE CAUSE (o	Art	eriosclerot	ic o	cardiovascula	r diseas	9		Years
	422.1	DUE TO								
	Conditions, if o		}							
	gove rise to i									
	lying couse lost.) (c)							
	PART II. OTI					NOT RELATED TO THE TERMIN	VAL DISEASE CON	DITION GIVEN	I IN PART 1	(o) 19. WAS AUTOPSY PERFORMED?
,	S Ps			ive reaction						YES NO D
	PART II. OTH	S UNDERLYING TO CAUSE OF DEATH MEDICAL EXAMINER	20Ь. DES	CRIBE HOW INJURY OCC	URRED	. (Enter noture of injury in P	ort I or Parl II of i	item 18.)		
	20c. TIME OF INJUR Hour a.m.	Y Month, Doy, Yes	20d. II While		De. PLA	CE OF INJURY (Home, form, ory, street, office bldg., etc.)	20f. (Cily or lov	rn)	(Cou	nly) (Stote)
		19	at wor	rk 🔲 at work 🔝						
	21. I certify th	at Lattended the	deceas	ed from Octob	er 2	24 , 19 58, to De	cember 2	., 19.58,	that I las	st saw the deceased
	alive on Dec	ember 2	, 12,5	(2), and that d	eath	accurred at 7:15	M, from the	causes an	d an the	date stated above.
	5	1. 1	4	1		A	DDRESS (Street, ci	ily or town, sto	ole)	DATE SIGNED
,	SIGNATURE G	and	1	cesa		o. Sprin	gfield S	tate Ho	spita	1
	PHYSICIAN'S	Edmund Lust	hane	M D		Carles		ome Person		
	220. BURIAL, CREMATIC REMOVAL (Specify)		F	22c. NAME OF CEMETI	ERY OR	CREMATORY	22d. LOCATION (P	county)	(Stole)
	23. FUNERAL DIRECTOR	S SIGNATURE	2	ADDRESS	16		NOODS		JAP'S SIGN	17D
	the 11-1 0 4	The To	(1)	and about.	-	las	4 '58			
	1154164	MUHAUK 21	1,00	couling		LA DATEDED	4 30	(, 24,		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18



with filed death. oug 2. papers. 0 amin ä d Ö ž puty Marsh, амез ۳ A by 20 3 shauld parordo FUNER poge o



	100	¢ U	CERTIF	-ICA	TE OF L	EATH			Reg. Dis	st. No.				
1. PLACE OF DEATH o. COUNTY	Carrol	L	MARYL	AND	O. STATE	Maryla		d lived. If institut b COUNTY		nidence before admission)				
b. CITY OR TOWN (I RURAL ond give no	f outside corporate lim	its, write	c LENGTH OF STAY IN	N lb	c. CITY OR T	OWN (If ou	tside corp	prote limits, write	RURAL ond	give negrest	lawn)	-		
Henr	yton		726 days]	Rock H	all		1	у #				
OR INSTITUTION	AL (If not in hospital, i				d STREET A			_		e. 1	S RESIDEN	CE		
Henr	yton State	Hosp	ital		Re	oute 1	, Bo:	x 9			S NO			
3. NAME OF DECEASED		rst	Middle		Losi		4. DATE	Mo		Doy	Year	′0		
(Type or print)		trude	Jeanet	-	Dash:	ields	OF DEATH	Dece	ember	31	19 5	8		
5. SEX		7. MARR	IED NEVER MARRIED	NEVER MARRIED B. DATE OF BIRTH 9. AGE (In years IF UND)							UNDER 24			
Female	Negro	WIDOWI	DIVORCED		October	1, 19	18	40 /30/n	Months	Doys H	ours M	lin.		
None None	ON (Give kind of work ung life, even if retired	done 10b.	KIND OF BUSINESS OR	INDUS			-	ryland		S.A.		NTRY?		
13. FATHER'S NAME					14 MOTHER'S							_		
	Joshua Ga	aines			Ros:	ie But	ler							
15. WAS DECEASED EVE	R IN U. S. ARMED FOR		SOCIAL SECURITY NO	17 II	FORMANT			Ade	dress					
No				0	ertrude	J. Da	shie.	lds - Pat	tient					
			e for (a), (b), and (c).]							INTERV	AL BETWEE	EN .		
PART I, DEA	TH WAS CAUSED BY: IMMEDIATE CAUSE (c)He	emorrhage							ONSET AND DEATH				
. X	DUE TO													
Conditions, if or		F	ar Advanced	Bil	lateral 1	Pulmon	ary !	luberculo	osis					
gove rise to it														
lying couse lost.) (0	1												
ZO PART II. OTH	fer significant con	IDITIONS C	ONTRIBUTING TO DEAT	TH BUT	NOT RELATED TO	THETERMIN	IAL DISEAS	E CONDITION GI	VEN IN PAR	P	VAS AUTO ERFORMED S NO)?		
	S UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER)	206. DES	CRIBE HOW INJURY OC	CURRED	, (Enter nature of	injury in Po	ort I or Po	rt II of ilem 18)						
20c. TIME OF INJUR Hour e. m. p. m.	Y Month, Doy, Ye 19	While	NOT while of work		CE OF INJURY (Flory, street, office		20f (Cit	y or town)	(<	County)	(\$	ilate)		
21. I certify the alive on Dece	ember 31,	, 1958	d fram Januar	ry I	accurred at	5:00 A	M, frai	c_31, 1956 m the causes street, city or town aryland	and an th	last saw he date :	the decistated a DATES	bave.		
PHYSICIAN'S DE			ılans, Supt	•	Henry	ton S	tate	Hosp i tal	. Hen	ryton	, Md.			
220. BURIAL, CREMATIO REMOVAL (Specify)	1/2/59	OF T	22c NAME OF CEMET	_	0	try	100	TION (City, lown,	or county)	lang-	(Sigle)	d		
23. PUNERAL DIRECTOR	S SIGNATURE	7	ADDRÉSS	1 -	lead	240 / REC'D			ISTRAR'S SIC	/				

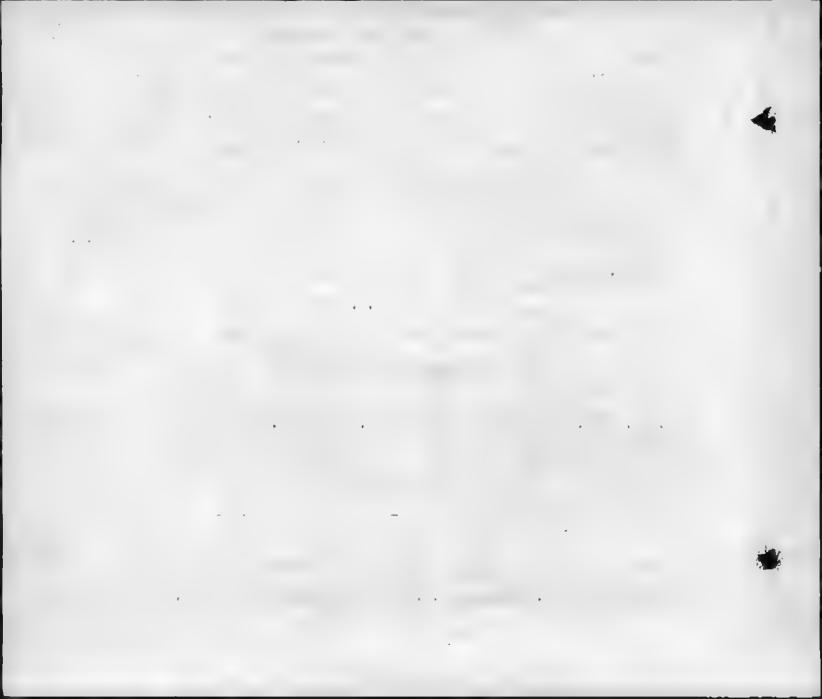
TO HOPPIAL OR ATTENDING INVSICIAN: The iom requime that the Leath certificate be executed within 21 hauss ofter death. Page A the funeral director. may be retained by the haspital or attending physician.

TO FUNERAL DIESCIOR: After this certificate has been signed by the attending physician on completely filled in by page 3 shauld retached far use as the burial-transit permit. Then please remave carbon papers. Pages 1 and 2 the registrar prime is burial, cremotion, ar removal, and in any event within 72 haurs after death. VS A15 (4) 15M 9/55



hours after death. Page

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 13572 CERTIFICATE OF DEATH director, 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission a. COUNTY filed b. COUNTY MARYLAND Carroll Marvland Montgomery era b CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) Rural) Sykesville, Md. 5yr.10mo.16days. Chevy Chase d NAME OF HOSPITAL (If not in hospital, give street address) d STREET ADDRESS or institution ield State Hospital e 15 RESIDENCI ON A FARM? 6705 15th. Street YES NO -NAME OF 4. DATE Middle Lost Yeor OF DEATH James X. DuBois 12 10 58 (Type or print) AGE (In years last birthday) S. SEX 6. COLOR OR RACE 7 MARRIED TO NEVER MARRIED B DATE OF BIRTH IF UNDER I YEAR IF UNDER 24 HRS Months Doys 1-9-1878 DIVORCED T Male White WIDOWED | yrs. 20 compl 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? death. during most of working life, even if retired) gug Bookkeeper Germany unknown after 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Richard Catlin DuBois Alice Sophia Richardson 15 WAS DECEASED EVER IN U. S. ARMED FORCES? 16, SOCIAL SECURITY NO 17. INFORMANT Address Hospital Records -- Springfield State Hospital unknown 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (o)_ 1-day Bilateral Progmenia and scute cardiac DUE TO Conditions, if any, which decompensation gove rise to immediate DUE TO couse (a), stoting the underlying couse lost. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY Chronic brain syndrome associated with circulatory disturbance, with PERFORMED? cerebral arteriosclerosis, with psychotic reaction. YES NO IX 200 ACCIDENT WAS UNDERLYING OF CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) 20c. TIME OF INJURY Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY [Home, form, 20f (City or town) (County) (Stote) Hour e. m. factory, street, office bldg., etc.) While Not while of work Tol work alive an___32-2 _, and that death accurred at 7 P.M. from the causes and an the date stated above. ADDRESS (Street, city or lown, state) DATE SIGNED ACTUAL SIGNATURE M.D. Springfield State Hospital RAL DIRO FUNERAL I PHYSICIAN'S NAME (Type) Walten Knopp Sykesyille, Manyland 22b DATE THEREO 220. BURIAL, CREMATION, 22c. NAME OF CEMETERY OR CREMATORY 22d LOCATION (City, town, or county) page Cedar Hill Suitland, Maryland 2 23. FUNERAL DIRECTOR'S, SIGNATURE **ADDRESS** 24o. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE

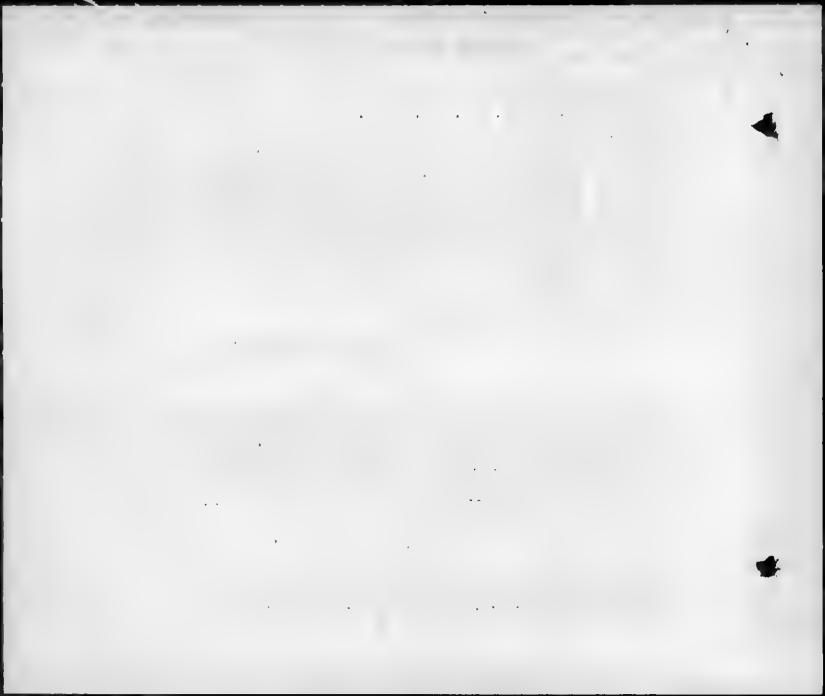
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haurs after death.

certificate

VS A15 (4)

15M 10/57



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

death.

physician

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signed

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15M 9/55



1357% CERTIFICATE OF DEATH

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1.	PLACE OF DEATH Carroll			ши	2	USUAL RESIDENCE (WHO STATE Maryland	ere decease	d lived. If institution b. COUNTY	Balt				
		f outside carporate limit	s, write	c. LENGTH OF STAY	IN 1b	c. CITY OR TOWN (If a	utside carpo	prote limits, write R					
L	Sykesvil	idrest fown) Le		12y.6m.3d.		Baltimore			01-				
	d NAME OF HOSPIT	AL (If not in hospital, g	ve street	oddress)		d STREET ADDRESS					e. IS RES		
L		ield State	Host	ital		400 400 400						NO X	
3.	NAME OF DECEASED	Fire	ıŧ	Middle	_	Lost	4. DATE	Mon	th	De	у	Yuor	
П	(Type or print)	NE		BEATR	ICE	DUNBAR	OF DEATH	Decembe	er 11			1958	
S.	SEX		7. MARR	IED NEVER MARRIE	8. 0	DATE OF BIRTH		9. AGE (In years	IF UNDE	RIYEAR	IF UND	R 24 HRS	
	Female	White	WIDOWI	DIVORCE		6-11-89		last birthday) 69 yrs.	Months	Days	Hours	Min	
10	. USUAL OCCUPATIO	N (Give kind of work of ing life, even if retired)	lone 10b	KIND OF BUSINESS O	R INDUSTRY	11 BIRTHPLACE (Stote	or foreign c	country)	12. CI	TIZEN C	F WHAT	COUNTRY	
	Sales	lady	18	has Horde	Stier	Marylar	id			U.	S.A.		
13.	FATHER'S NAME		3 6 5 6	1	- 00 0	4. MOTHER'S MAIDEN N					10 4 4 4 1		
П	John C	lark Cawoo	a	/		Harriet	Holme	8					
15.	WAS DECEASED EVE	R IN U. S. ARMED FOR	CES? 116.	SOCIAL SECURITY NO	. 17. INFO	RMANT		Add	P11				
ĮΫ	IS no or unknown)	(If yes, give war or dates of se	KAICO)	TINE	1	Records, Spr	ringfi			nite	1		
F		The feet and the second	. 1	chenn			41164.1	cza sogoe	1103				
Н		TH [Enter only one co TH WAS CAUSED BY				3 7				ONS	ONSET AND DEATH HOURS		
	1/63× IMMEDIATE CAUSE (6) ACCUSE DULINOTIES CHIED LIST												
	4000	DUE TO	(T)										
	Conditions, if or		Tr	rombophleb	itis,	left leg					Days	3	
	gave rise to in cause (a), stating t												
	lying couse lost.	(c)											
Z	PART II. OTH	ER SIGNIFICANT CON	DITIONS C	ONTRIBUTING TO DEA	ATH BUT NO	T RELATED TO THE TERMI	NAL DISEAS	E CONDITION GIV	EN IN PAI	RT 1(a) 1	9. WAS	AUTOPSY	
ΙĒ	S	chizophren	ic re	action. pa	ranoi	d type						RMED?	
ΙĔ	20g. ACCIDENT WA	S UNDERLYING IT				Enter nature of injury in f	ort I or Por	rt II of item 18)					
CERTIFICATION	OR CONTRIBUTING	CAUSE OF DEATH											
	20c. TIME OF INJUR		r 20d II	JURY OCCURRED	20e. PLACE	OF INJURY (Home, farm	206 (Cit)	v or lawn)		County)		(State)	
MEDICAL	Hour e. m.	19	While	Nat while	factor	, street, office bldg., etc.	}	,,	,	Coomy		(Sidie)	
2	p, m,		of work	17	1 0	- m							
		of lattended the	decegs	d from Marc	n_(,	., 19 <u>55</u> ., ta., De	cembe	r 11 1958	"that I	last so	w the	deceased	
	alive on	ember 11	_, 1921	and that	death ac	curred at 7:15 F	_M, frai	m the causes a	nd on t	he da	te state	ed abave	
		7-1		, A	1		ADDRESS (S	treet, city or town,	stote)		D/	ATE SIGNED	
П	ACTUAL	2 06 17	a1	CATTE	M.D	Sprin	field	State Ho	espit	al	12-	12-58	
	PHYSICIAN'S NAME (Type)	Acustin de	1 Can			Svices	rille.	Maryland	1				
22	- BURIAL CREMATIO			22c. NAME OF CEME	TERY OF C			TION (City, town, o					
	REMOVAL (Specify)	10 17	50	Walle of CEME	LA THY	EMATOR!	ald. LUCA	TION (City, town, o	r county)	-	(State	e)	
000	menters	15-1/2.	20	1 per (RIKE	MIKI	1-	MAMER	1		MI	~	
23.	FUNERAL DIRECTOR	SIGNATURE	1 1 10	ADDRESS	W	240 REC'S	BY REGIS	TRAR 246, REGIS	TRAR'S SI	GNATU	KE,		

ATTENDING INVSICIAN: The law requires that the death certificant be executed within 21 hours ofter death. Hage 4 funeral director. may be retained by the haspital ar attending physician.

O FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by I page 3 shauld

Estached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2s, the registrar prior to burial, crematian, ar remayal, and in any event within 77 frours offer death. may be retained by TO FUNERAL DIRECTORS **10 HOIPIAL OR** VS A1S (4) 15M 9/\$\$



L		20		CERT	IFICA	CIE OF D	EATE			Reg. Di	st. No.		
1	PLACE OF DEATH	Carroll		MAR	YLAND	- PT / TP	ence (who		d lived If institut b. COUNTY	Mont	gome:	e odmis	sion)
	b CITY OR TOWN	(If outside corporate limits, searest town)	write	c LENGTH OF STAT					rote limits, write		give nea	rest low	n)
L	Sykesvil			9mos. 2	days	S11	ver S	pring	, Route	#2		7.	¥
	OR INSTITUTION	ITAL (If not in hospite), giveled State Ho		_		d STREET AI	None					ON A	SIDENCE A FARM?
3	NAME OF DECEASED (Type or print)	J ohn	Wi:	Middl Lliam	le	Duvall		4. DATE OF DEATH	Decem	•	30		Yeor 19 58
5.	SEX	6. COLOR OR RACE	MARRI	D M MONEY		B. DATE OF BIRTH	1		9. AGE (In years	IF UNDE		IF UND	ER 24 HRS.
	Ma le	White	-			July 24	, 188	4	lost birthday)	. Months	Days	Hours	Min
10	dyr ng most of wor Farmer	ION (Give kind of work do rking life, even if retired)	ne 10b K	FARM	OR INDUS		yland	or foreign c	ountry)	12. CI	U.S		T COUNTRY?
13	FATHER'S NAME			HAZI		14 MOTHER'S	MAIDEN N	AME					
	Edward D	uvall				Kath	erine	Lent					
	WAS DECEASED EV	ER IN U. S. ARMED FORCE (If yes, gave war or dates of serv		OCIAL SECURITY N	-	FORMANT pringfie	ld Ho	spita	1 Record	dress			
	18. CAUSE OF DE	ATH [Enter only one cour	e per Rni	for (o), (b), and (c].]								ETWEEN
l	PART 1. DE.	ATH WAS CAUSED BY: IMMEDIATE CAUSE (0)_	Thr	combophlet	oitis	right	leg				M	onth	DEATH
ı	420.0	DUE TO											
	Conditions, if	ony, which) (b)	Art	erioscler	cotic	heart d	iseası	В			Ye	ears	ľ
	gove rise to	immediate (· · · · · · · · · · · · · · · · · · ·				
	tying cause lost.												
CERTIFICATION	C.B.S. as		ebra.	NTRIBUTING TO DE	cier	NOT RELATED TO	h psy	choti	c reacti	VEN IN PAI	RT 1(o) 11	PERFO PERFO YES	AUTOPSY PRMED?
CERTIFI	20g. ACCIDENT W OR CONTRIBUTING (IF EITHER, NOTIF)	'AS UNDERLYING G CAUSE OF DEATH Y MEDICAL EXAMINER)	06. DESC	RIBE HOW INJURY	OCCURRED). (Enter nature of	enjury in P	ort I or Par	t II of item 18)				
MEDICAL	20c. TIME OF INJU Hour a m. p. m	RY Month, Day, Year	20d IN While" at work	URY OCCURRED Not while	20e. PLA foc	CE OF INJURY (Flory, street, office	lome, farm, bldg., etc.)	20f. (Cih	or town)	(County)		(Stote)
	actual signature	hat I attended the cember 29,	, 195	and the	ch 28	occurred at.	7:45 ngfie	AM, fran Nooress (S 1d Ho	30, 19 5 In the causes Ireel, city or lown Spital ryland	and an t		e stat	
22		ON, 226. DAYE THEREOF	-9.	22c. NAME OF CEA	METERY OI	1/2 7	en	228 LOCA	MON (City, town,	or county)	Rec	(Sto	10) engl
23	COLUMN TO	Tillenel	Person	ADDRESS /	el	med	240 REC'D	BY REGIST	FRAR 246 REG	ISTRAR'S SI	GNATUR		



CERTIFICATE OF DEATH

13567

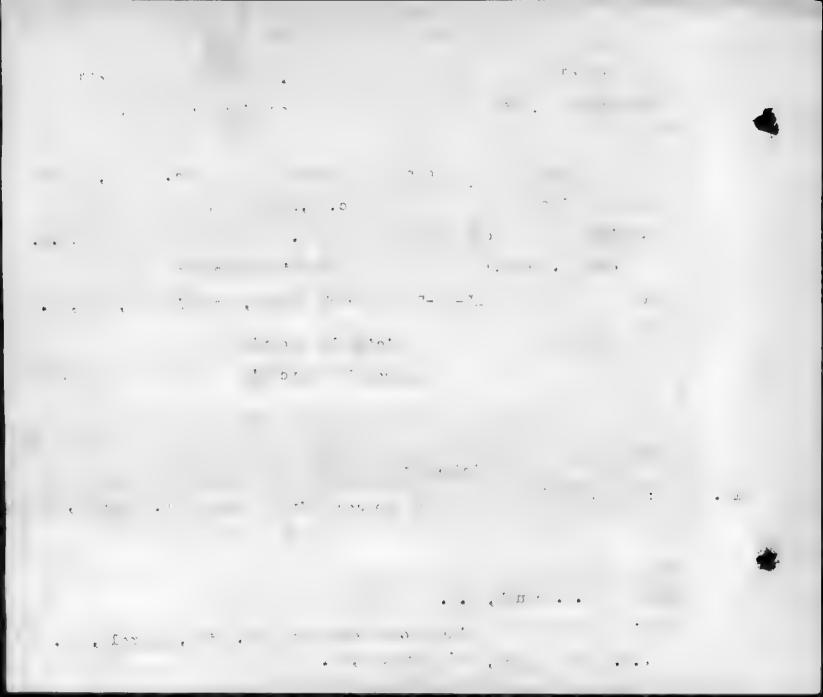
					Keg, Dist, No.							
)	1. PLACE OF DEATH COUNTY Carroll	MARYLAND	2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o STATE Maryland b. COUNTY Washington									
4	b. CITY OR TOWN (If outside corporate limits, wi RURAL and give nearest town)			utide corporete limits, write RUR	RAL and give nearest town)							
1	Sykesville	2yrs.7mos.28da		own	· · · ·							
	d. NAME OF HOSPITAL (If not in hospital, give s OR INSTITUTION	freet oddress)	d STREET ADDRESS		e. 15 RESIDENCE ON A FARM?							
	Springfield State Ho	spital	329 S.	Mulberry St.	YES NO 2							
	J. NAME OF DECEASED (Type or print) Freda Do	rthea Gohm Fr	tosi 26	4. DATE Month Of DEATH Dece mbe	o _{oy} Yeor er 29 19 58							
			July 5, 1880		FUNDER I YEAR IF UNDER 24 HRS. Months Doys Hours Min.							
	100. USUAL OCCUPATION (Give kind of work done during most of working life, even if ratired)	106. KIND OF BUSINESS OR INDUST	RY 11 BIRTHPLACE (Stote of	or foreign country)	12. CITIZEN OF WHAT COUNTR							
	Housewhite	-	Penna.		U.S.A.							
1	13. FATHER'S NAME		14 MOTHER'S MAIDEN N									
١	Lawrence figure Gohn		Caroline F	losenthal								
j	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give wer or dates of service)		FORMANT	Address	1							
	No -	- Sp	ringileto nos	spital Records								
1	18. CAUSE OF DEATH [Enter only one couse p	per line for (a), (b), and (c).]			INTERVAL BETWEEN							
1	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)	Cerebral hemorrh	a pa		Days							
1	DUE TO			***************************************								
	Conditions, if ony, which) (b)	Generalized arte	riosclerosis		Years							
1	gove rise to immediate		110001010010									
١	lying couse lost.											
	PART II OTHER SIGNIFICANT CONDITION	ONS CONTRIBUTING TO DEATH BUT N	OT RELATED TO THE TERMIN	NAL DISEASE CONDITION GIVEN	N IN PART 1(a) 19. WAS AUTOPSY PERFORMED?							
	C.B.S.assoc.with sen	ile brain disease	with psychol	old reaction.	YES NO A							
	PART II OTHER SIGNIFICANT CONDITION C.B.S.assoc.with sen 200. ACCIDENT WAS UNDERLYING [] OR CONTRIBUTION [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	DESCRIBE HOW INJURY OCCURRED	(Enter noture of injury in P	ort I or Port II of Item 1B)								
1		od. INJURY OCCURRED 20e. PLAC	CE OF INJURY (Home, form,	20F (City or town)	(County) (Slote)							
	Hour o m.	Vhile Not while focts	ory, street, office bldg., etc.		(County) (Stote)							
		t work ot work										
	21. I certify that I attended the dec				that I last saw the decease							
1	alive on December 29,	19 <u>/58</u> , and that death (occurred at 9:44	M, from the causes an	d on the date stated abov							
1	C / / *	t ++		ADDRESS (Street, city or town, sto	DATE SIGNE							
1	SIGNATURE 20 1000 0 1	Llesthou	D. Springfield	d State Hospita	1 12/29/58							
	PHYSICIAN'S	11 N.D	Coolea and 1.2 a	36								
1		sthaus, M.D.	Sykesville									
	220 BURIAL, CREMATION, 22b. DATE THEREOF	224. NAME OF CEMETERY OR	CREMATORY	22d. LOCATION [City, town, or	county) (Stote)							
	NURIAL 12/3/13	1 Kest HAVEN	(enclosy)	HAGERS to a	n Mt							
	23 FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	,		RAR'S SIGNATURE							
1	Kest/Anden Funerall	GADAT HASERS	10 w n/ CATEDS	31 20	UN S. Thomas							

George It & Sffertinger

may be retained by the haspital or attending physician.

TO FUNERAL DIR FIGH. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should to acked far use as the burial-transit permit. Then please remove carbon pagers. Pages 1 and first the filed with the registrar prime to burial, cremation, or remayal, and in any event within 72 hours after death. ID HORPIAL OR ATTENDING PHYSICEN: The faw requires that he death certificate be executed within In hours after distributed to V\$ A15 (4) 15M 9/55





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 13569 13578 **CERTIFICATE OF DEATH** Reg. Dist. No PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) Maryland a. COUNTY Carroll b. COUNTY MARYLAND Wicomico b. CITY OR TOWN (If outside carparate limits, write c LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town) RURAL and give nearest town Henryton Salisbury d NAME OF HOSPITAL (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE OR INSTITUTION ON A FARM? Route #2. Delware St. Extended YES NO TO Henryton State Hospital NAME OF 4. DATE Middle Year OF DEATH (Type or print) Frank Garrison December 20. 19 58 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED | B. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS P. AGE (In years last birthday) Months Hours Mala WIDOWED [DIVORCED | 10-12-1899 Negro 10a. USUAL OCCUPATION (Give kind of work dane) 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) Laborer South Carolina U. S. A. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Frank Garrison, Sr. Sally Linden 15 WAS DECEASEDEVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address Yes War Frank Garrison - Patient CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART 1. DEATH WAS CAUSED BY Cerebrovascular disease IMMEDIATE CAUSE (a) DUE TO Conditions, if ony, which gave rise to immediate **DUE TO** cause (a), stating the under-Moderately advanced pulmonary tuberculosis lying couse last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19, WAS AUTOPSY PERFORMED? YES NO 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Port I or Part III of item 18.) 20e PLACE OF INJURY (Hame, farm, 20f (City or fawn) 20c. TIME OF INJURY Day, Year 20d. INJURY OCCURRED (County) (State) factory, street, affice bldg., etc.) Haur a. m. Not while at work at work 21. I certify that I attended the deceased from June 17 ., 19.58, to December 20 19.58, that I last sow the deceased 19.58 and that death occurred of 1:40AM, from the causes and an the date stated above. ADDRESS (Street, city ar tawn, state) DATE SIGNED M. Maen lavey ACTUAL SIGNATURE Henryton, Maryland PHYSICIAN'S Dr. Edgars M. Maculans. Supt. Henryton State Hospital, Henryton, Md. NAME (Type) 220. BURIAL, CREMATION, 226. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d LOCATION (City, town, or county) (Stale) REMOVAL (Specify) FUNERAL DIRECTOR'S SIGNATURE ADDRESS S 240. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE I'm & Traus DATEC 2 9 58

death.



FOR STATE HEALTH DEPT.

123

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 13579 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. I		^	13	5	7	0
Reg. I	Dist.	No.	a	-	7	.,

		PLACE OF DEATH					2. USUAL RESIDENCE (V	Yhere decea			e before admiss an)	
	L.	Carro	011		MARYL	AND	o. STATE Mary	yland	P COUNT	Y Balti	more	
	ь	ond give express fown	autside corporate him is, wit	◆ MJKAL	c. LENGTH OF STAY IN	1 1b	c. CITY OR TOWN (If	autside cor	porate limits, write	RURAL and gr	ve neorest town)	
1		Šykesvi		.)	19y.4m.14d.	.	Baltin	nore		03x	2	
	d	. NAME OF HOSPIT	AL OR INSTITUTION	If not in hos	pital, give street address)		d. STREET ADDRESS			e. IS RESIDENCE		
meger		Spring	Tield State	Hosp	ital		3439 Ever	rhart	Street	YES NO		
	1	NAME OF DECEASED (Type or print)	Fir EV	er MA	Middle		HARRIS	4. DATE OF DEATH	Decemb		19 58	
	5. S	EX	6. COLOR OR RACE	7 MARRIE	D NEVER MARRIED	[] ð.	DATE OF BIRTH		9. AGE (In years lost_bigthday)	IF UNDER 141		
		Temale	White	WIDOWE	DIVORCED	ונ	Unknown		66 yrs	Months Da	ys Hours Mr.	
	10o	. USUAL OCCUPATION	ON (Give kind of work g life, even if relired)	dane 10b. K	(IND OF BUSINESS OR IN	DUSTR	11. BIRTHPLACE (Stote	or foreign e	country)	12. CITIZE	N OF WHAT COUNTRY	
		Housew:					Marylan	nd			U.S.A.	
	13.	FATHER'S NAME					14. MOTHER'S MAIDEN N	MAME				
		Ur	nknown				Unknown	n				
		WAS DECEASED EV	ER IN U. S. ARMED FO		SOCIAL SECURITY NO	17. IN	ORMANT		Address			
	1.00	No	(in yes, give war ar eares or	JOST TO STATE OF THE PARTY OF T		Spr	ingfield Sta	ate Ho	spital R	ecord		
		18 CAUSE OF DEA	IH [Enter only one cou	se per ine	far (a), (b), and (c).]					= 7	INTERVAL BETWEEN	
		PART I, DEAT	H WAS CAUSED BY:	C	oronary occi	lusi	.on				ONSET AND DEATH	
		420.1	DUE TO									
		Conditions, if a	ny, which } (b)									
		gave rise to immed	liate cause	·								
		(a), stating the cause last.	(c)									
	3	PART II. OTH	IER SIGNIFICANT CON	DITIONS CO	INTRIBUTING TO DEATH	BUT NO	T RELATED TO THE TERM	NAL DISEAS	E CONDITION GIV	EN IN PART 1	o) 19. WAS AUTOPSY	
)	CERTIFICATION		Involutions	al psy	chotic react	tion					YES NO X	
	(TTF)	20g. EXTERNAL CAL PRIMARY gr COI	ISE WAS	b. DESCRIBE	HOW INJURY OCCURR	ED (En	er nature of injury in Parl	1 tor Fort it	of item 18)			
		CAUSE OF DEATH.										
	MEDICAL	20c TIME OF INJUI	RY Month, Day, Yes			PLACI	OF INJURY (Home, form y, street, office bidg, etc.	20f (City	r or town)	(County	(State)	
	ME	Hovr o.m. p.m.	19	While of wo								
		21. I certify the	ot I took charge	of the r	remoins described	obov	e, h <mark>eld on Autops</mark>	y 🔲 . II	nspection 🔀	Inquiry	X, and in my	
		opin on death	esulted from: 1	Natural c	auses 🗷 . Accide	ent [], Suicide 🔲, I	Homicide	. Undete	rmined mo	nner 🔲	
		[[/	, ,	1) Ly	1	1						
n .		SIGNATURE A	lemus S	. /	hanh		M D. CHIEF MEDICAL EX	CAMINER [20.25	DATE SIGNED	
7,		EXAMINER'S					ASSISTANT MEDICA	AL EXAMINE		12-15-	-50	
		NAME (Type)	James T. 1	larsh,	M. D.		DEPUTY MEDICAL I	EXAMINER [N .			
	220	REMOVAL (Specify)	N. 226 DATE THEREC	r .	222 MAME OF CEMETER	YORG	REMATORY	22d 100%	JION (City, town,	or county)	(Stole)	
	L			.18	1. 7 111.	111	alley 170	PA !	1200	inner	2,190	
Y	23.	FUNERAL DIRECTOR	S-SIGNATURE	P/ ;	ADDRESS /	//	240. REC'I	D BY REGIST	RAR 246 REGI	STRAR'S SIGNA	ATURE '	
-	1	1423111 YY	. 110ust1	1/2	M. Ferry X	,	DATE	10.0.1.11	0 1 0.	12mm & 40	raud	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be farzered to the Chief Medical Examiner's Office along with form PM3. Page 5 may be relained for your files.

TO FUNERAL DICEOUR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Back Health, or its designated against a prior to burial, cremation, ar remayal, and in any event-within 72 hours after death. VS ATSME 5M 2/57



. . .

.

12-15-1958

23 FUNERAL DIRECTOR'S SIGNATURE

C. M. Waltz.

Pine Grove

ADDRESS

Winfield, Maryland

0

VS. A15ME

5M 2/57

IS RES DEN ON A FARM?

YES NO

IFUNDER TYEAR IF UNDER 24 HRS.

Hours

12. CITIZEN OF WHAT COUNTRY?

INTERVAL BETWEEN

munca

PERFORMED? NO D

(State)

and in my

DATE SIGNED

(State)

Doys

(County)

Inquiry St.

Mt. Airy, Laryland

24b REGISTRAR'S SIGNATURE

240 REC'D BY REGISTRAR

DATE DEC 1 5

Rea. Dist. No.

Carroll

Months



				358.	1	CERTIFI	CA	TE OF DEAT	H			Reg. D	ist. No.	10	15/7
	1. (COUNT Carre	011			MARYLAN	- 11	2 USUAL RESIDENCE (W O STATE Maryla	here decesse nd		institutia OUNTY		nce befor		tion)
		RURAL ond give n	ville		15y	., 25d.	b	c. CITY OR TOWN (If outside corporate limits, write RUR. Unknown.					give neo	irest law	n}
15		OR INSTITUTION	TAL (If not in hospitel, g pringfield	ive street State	oddress) e Hos	pital		d STREET ADDRESS					e. IS R ON YES [
	3.	NAME OF DECEASED (Type or print)		LIAM		Middle GFCRŒ		HIDEEN	4, DATE OF DEATH	I		ber			Year 1958
	5. \$	Male	6. COLOR OR RACE White	WIDOWI	ED 🗍	DIVORCED P		1-26-84		9. AGE (II last bir 7.	thday)	Months	Doys	Hours	ER 24 HR
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			hard R. Hid		505111.5	POURITY NO. 11	7 2011	14. MOTHER'S MAIDEN Katherine ORMANT			Addre				
	(Ye)	NO or unknown)	(19 yes, give war or dates of s	ervice)				cords, Spri	ngfiel	Ld Sta					
			ATH (Enier only one co ATH WAS CAUSED BY: IMMEDIATE CAUSE (o DUE TO	My		lial infa	rc	tion					ONS	RYAL BE	DEATH
		Conditions, if a	iny, which) (b	Coi	ronar	y throm	os:	is				· —	I	Days	
	NOI	lying couse lost	lue ouder-	Ar				heart diseas		SE CONDITI	ON GIVI	N IN PAI		Zear:	
3	CAT		Manic dep	ress	ive r	reaction	m							PERFC YES [ORMEDZ
3	AL CERTIF	(IF EITHER, NOTIFY	AS UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER) RY Month, Day, Ye		NJURY OC										10.
	MEDICAL	Haur a.m. p.m	19	While of wor	rk 🔲 of w	while vark	facto	E OF INJURY (Home, for iry, street, office bldg., et	c.)		-20		(County)		(State
		21. I certify the alive on <u>De</u>	nat I attended the cember 17	deceas	ed from	March and that de	ath o	, 195 , to 1 accurred at 3:15		m the ca	uses a	nd an I	lost so the dat	te stat	ed abo
		ACTUAL SIGNATURE	72.2711	ist	4.	iifi.	м	o. Spri	ADDRESS (S				ital		ATE SIGN
	-		Agustin del			. D.			svill						
The same of the sa		BURIAL CREMATIC REMOVAL (Specify BURIAL FUNERAL DIRECTOR	Dec. 21.	1958	3 5	t. Mary	_	Cometery	St. 1	TION (City	s Ci	175		(Sto)	100
j	23.		nder & So	no I			er	Mel DATE DE	O BY REGIS	S8 24	a. KEGIS	traris si	Hian	d	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. Page 4



deoth. Poge

hours after



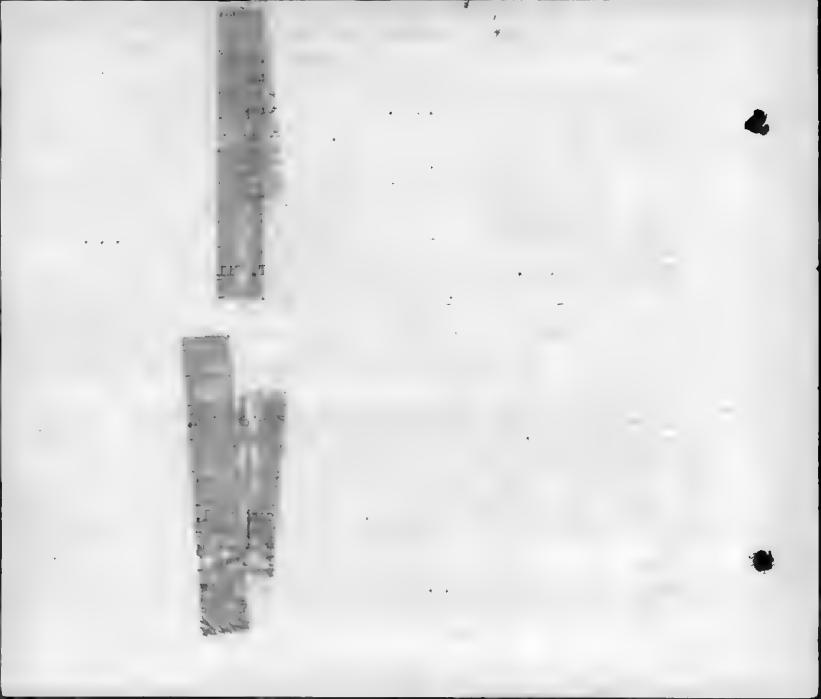
deoth.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



Reg. Dist. No. 2. USUAL RESIDENCE (Where desected lived If institution: Residence before admission) Baltimore City c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) . IS RESIDENCE ON A FARM? YES NO NO Month 10 58 December IF UNDER I YEAR IF UNDER 24 HRS Dovs 12. CITIZEN OF WHAT COUNTRY? U.S.A. Artriess INTERVAL BETWEEN ONSET AND DEATH Yaars Years Psychosis due to convulsive disorder, epileptic deterioration. Part 1(0) 19. Was autopsy performed? YES NOTE (County) (State) 21. I certify that I attended the deceased from October 20. 19 54, to December 21, 19 58, that I last saw the deceased _____, 19<u>/58</u>___, and that death accurred at <u>8.246P</u>_M, from the causes and an the date stated above. A Springfield State Hospital 22d LOCATION (Cibr/town, or county) (Stote)/ 24b REGISTRAR'S SIGNATURE 7 1 1 A S. Kroug

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 13585 **CERTIFICATE OF DEATH** N. Rea. Dist. No. il director, filed with Page 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. COUNTY MARYLAND lungy haurs after death. b. CITY OR TOWN (If outside corporale limits, write c. CITY OR TOWN (If autside corporate li c. LENGTH OF STAY IN 16 M. and give hearest town) arist d. NAME OF HOSPITAL (If not in haspital, give street address) d. STREET ADDRESS **OF INSTITUTION** 22 and an NAME OF DECEASED Middle Lost 4. DATE Poges 1 OF DEATH (Type or print) SEX 6. COLOR OF RACE 7. MARRIED T NEVER MARRIED T R. DATE OF BIRTH 9. AG las mapo WIDOWED CA DIVORCED 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHTTACE (State or fareign cauptry) during most of working life, even if retired) puo corbon ofter 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME physician 6 21/18 move hours S. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL'SECURITY NO. 17_INFORMANT attending 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (d.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate ž. **DUE TO** cottse (a), stating the underlying couse last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CON 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part II or Part II of ATTENDING PHYSICIAN: 20c. TIME OF INJURY Month, 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form. 20f. (City or lov factory, street, office bldg., etc.) a. m. While Not while at work at work 21. I certify that I attended the deceased from, and that death accurred M. fram the ADDRESS (Signal, o ACTUAL SIGNATURE

22c, NAME OF CEMETERY OR CREMATORY

ADDRESS

22d. LOCATION

24a. REC'D BY REGISTRAR DATE DEG 3 0 58

b. COUNTY Check
mits, write RURAL and give nearest lown)
// **
dramy P. IS RESIDENCE ON A FARM? YES NO DE
Mailth Day Year
Decarber 27 1958
E (In years IF UNDER 1 YEAR IF UNDER 24 HRS. brilday) Months Days Hours Min.
12. CITIZEN OF WHAT COUNTRY?
Suca M. S.A.
enelas X
Address
arrail 14
INTERVAL BETWEEN ONSET AND DEATH
4
DITION-GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES \(\bigcap \) NO \(\bigcap \)
tem 18.)
(County) (State)

., 1922, that I last saw the deceased
causes and an the date stated above. by or town, stote) DATE SIGNED
A May but 12-27-58
Maryland
City, town, or county) (State)
24b. REGISTRAR'S SIGNATURE CITCHES S. Trous

TO FUNERAL E VS A15 (4) 15M 9/SS

HOSPITAL

0 20 should

PHYSICIAN'S NAME (Type)

220 BURIAL PREMATION.

REMOVAL (Specify)

23. FUNERAL DIRECTOR'S SIGNATURE

226. DATE THEREOF



- 1	9	1	7	100
1	Ð	U	á	1

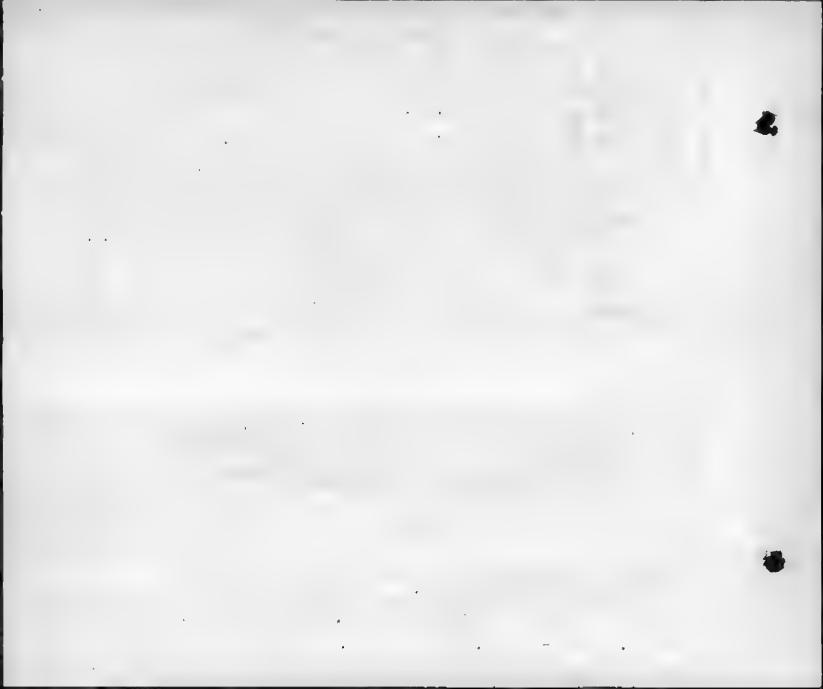
135	86 CERTIFIC	ATE OF DEATH	ł .	Reg. Dist. No.	TOO
1. PLACE OF DEATH a. COUNTY	MARYLAND	2 USUAL RESIDENCE (Who o. STAJE	ere deceased fived. If ins b COU		
Carroll		o. star		Dalfilmor	
b. CITY OR TOWN (If autside corporate fimils, write RURAL and give nearest town)		c. CITY OR TOWN (If a	utside carporote limits, wr	ile RURAL and give nea	irest tawn)
Sykesville	6y.3m.15d.	Baltimor	re	3V.1	4
d NAME OF HOSPITAL (If not in hospital, give stree OR INSTITUTION	· ·	d STREET ADDRESS			e. IS RESIDENCE
Springfield State	Hospital	642 Gorsu	ch Ave.		YES NO X
3 NAME OF First DECEASED (Type or print) MARTHA ELIZAT	Middle BETH PORTER KET	N Lost	4. DATE OF DEATH Decemb	Month Do	y Yeor
TO 1 271 13	RRIED MEVER MARRIED DIVORCED DIVORCED	B DATE OF BIRTH	9. AGE (In ye lost birthdo	ears IF UNDER I YEAR ay) Months Days yrs.	Hours Min
10a USUAL OCCUPATION (Give kind of work done 10 during most of working life, even if retired)	KIND OF BUSINESS OR INDU	JSTRY 11. BIRTHPLACE (Stole	or foreign country)	12 CITIZEN O	F WHAT COUNT
Housewife		Maryland	F	IJ.,	S.A.
13 FATHER'S NAME		14 MOTHER'S MAIDEN N	AME		
Robert Porter		Carolin	ne Loar		
15. WAS DECEASED EVER IN U S. ARMED FORCES? 1	6. SOCIAL SECURITY NO. 17.	INFORMANT		Address	
(Yes, no, or unknown) (W yes, give wor or dates of service)		Records, Spri	ingfield Sta	te Hospita	1
18. CAUSE OF DEATH [Enter only one couse per	line for (o), (b), and (c) }			LINTE	ERVAL BETWEEN
PART I DEATH WAS CAUSED 8Y:	Arterioscleroti	e cardiovascul	lar disease	ONS	SELAND DEATH
4 2 21 IMMEDIATE CAUSE (6)					20.120
Conditions if one which t					
gove rise to immediate					
lying couse lost.					
101	CONTRIBUTING TO DEATH BU	T NOT RELATED TO THE TERM	NAI DISEASE CONDITION	GIVEN IN PART 1(a)	9 WAS AUTOPSY
Fulmonary tuberculosis C.B.S. assoc. with sen	, moderately a	dvanced, inact	ive.		PERFORMED?
200 ACCIDENT WAS HINDERLYING TO 1206 DE	THE LIBIT COURT	Se With peyo	hotic react	ion L	YES NO
Pulmonary tuberculosis C.B.S. 2550C. With 5en 200. Accident was underfund [] OR CONTRIBUTION [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	12 V	to femal moisile of inforty in t	off to fact to them to	'	
	INTURY OCCUPPED 120- M	LACE OF INJURY (Home, form	206 ((7))	100	40.
A Hour o.m. Whit	a Not white fo	ectory, street, office bldg., etc.) i	[County]	(Stole
	ork ol work		1	70	
21. I certify that I attended the deced	ised from Farch (, 19 <u>55</u> , ta De	cember 12, 19	. 2년, that I last so	w the deceas
alive on December 12 , 19	_55, and that deot	occurred of 1:45			te stated aba
	.00		ADDRESS (Street, city or to		DATE SIGN
SIGNATURE LITTON LOLE IL	il it sike	M.D. Spring	field State	Hospital	12-12-58
PHYSICIAN'S Agustin del C	ampo, M. D.	S; kesv	ille, Maryla	and	
270. BURIAL, CREMATION, 276 DATE THEREOF 12/15/58	raendship	or CREMATORY Noth Church	PALLS COI)	wn. of sounty land	(Stole)
23. FUNERAL DIRECTOR'S SIGNATURE -3000	E. Apprestimore	St. 240 REC'I	BY REGISTRAR 24b F	REGISTRAR'S SIGNATUE	XE.

moy be retained by the hospitol ar attending physician.

D. FUNERAL DY CR: After this certificate has been signed by the ottending physicion and campletely filled in by the page 3 should of detoched far use as the burial-transit permit. Then please remove carban papers. Pages 1 and 2 the registror prior to burial, cremation, or removal, and in any event within 72 hours after death. TO HOSPITAL OR moy be retained TO FUNERAL DR VS A15 (4) I5M 10/57

funeral director, d be filed with

ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours ofter deoth. Page 4



13587

CERTIFICATE OF DEATH

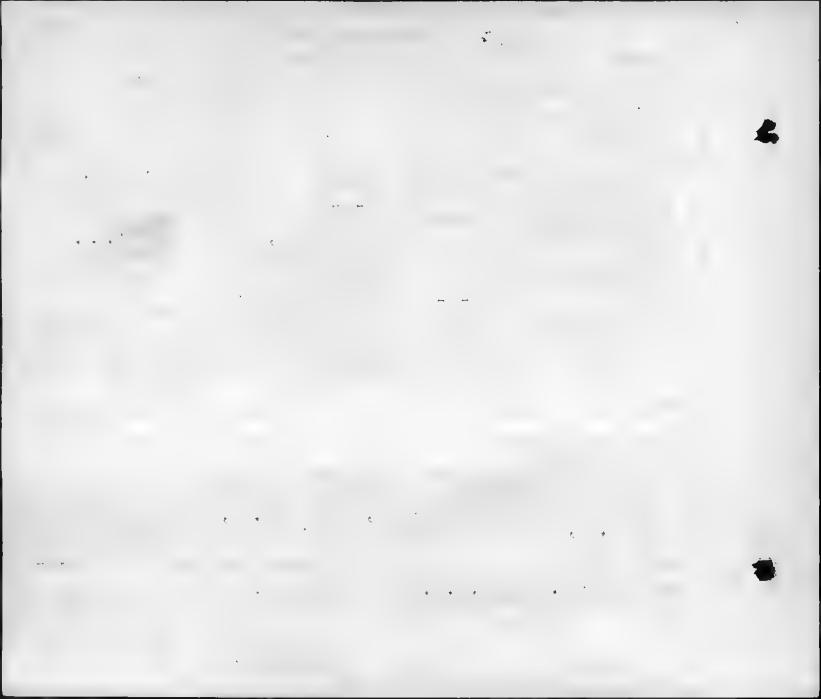
Reg. Dist. No. 13578

									Magi ata		
0. C	CE OF DEATH OUNTY Carroll			MARYL	11	usual RESIDENCE (Who STATE Maryland	ere decease	d lived If institute b. COUNTY	on Residence	_	dmission)
b C	ITY OR TOWN (II	outside corporate limi	ls, write	c LENGTH OF STAY I	IN 1b	c. CITY OR TOWN (IF o	utside corpo	erate limits, write R			town)
Rt	Henryton			262 days		Harve de	_			. 44	- 1
d N	NAME OF HOSPITA	AL (If not in haspital, g	ive street	oddress)		d STREET ADDRESS				0. 15	RESIDENCE
		State Hos	pita	1		Elizabeth	Stre	et			S NO
3. NAA	ME OF EASED	Fir	of	Middle		Lost	4. DATE	Mar	ith	Day	Yeor
	e or print)	. Da	niel			Keys	DEATH	Decemb	er	14,	19 58
5. SEX		6. COLOR OR RACE	7. MARR	IED NEVER MARRIE	D B D	ATE OF BIRTH		9 AGE (In years lost birthdoy)		YEAR IF L	INDER 24 HRS
	Male	Negro	WIDOW	DIVORCED	6	-22-1906		52' yrs	Months I	Days Ho	iors Min
10a. US	SUAL OCCUPATIO	N (Give kind of work a	done 10b.	KIND OF BUSINESS OF	RINDUSTRY	11. BIRTHPLACE (Slote	or foreign c	ountry)	12. CITI	ZEN OF W	HAT COUNTRY?
	Unknown	ing ine. even ir remred				Middlesex		yland	1	J.S.A	•
R3. FATI	HER'S NAME				1.	MOTHER'S MAIDEN N	IAME				
1	Hezekial	і Кеуз				Annie Key	s?				
15. WA	S DECEASED EVER			SOCIAL SECURITY NO	17. INFO	RMANT	,	Add	ress		
(185, no.	NO (It yes, gave war or dates of s	Prvice]	218 -01- 5327	Da	niel Keys -	Patie	ent			
18.		•	use per lir	ne for (o), (b), and (c).)							L BETWEEN
	PART I. DEAT	TH WAS CAUSED BY: IMMEDIATE CAUSE (6)	Ca	rdiovascula	r ins	ufficiency				ONSEL	AND DEATH
	160X	DUE TO								1	
1 6	onditions, if or		Car	rcinoma of	both	lungs					
	ove rise to in	mediate									
	ouse (o), stating thing couse lost	he under-									
) (c		ANTOINITING TO ALL	THE PLANT AND	COLUMN TO SUR TONIU					
[E	PART II. OIH	EK SIGNIFICANT CON	DITIONS C	UNIKIBUTING TO DEA	TH BUT NO	RELATED TO THE TERMI	NAL DISEAS	E CONDITION GIV	EN IN PART	1(a) 19 V	ERFORMED?
										YE	S NO
L CERTIFICATION	ACCIDENT WAS CONTRIBUTING EITHER, NOTIFY	S UNDERLYING [] CAUSE OF DEATH MEDICAL EXAMINER)	206. DESC	CRIBE HOW INJURY OC	CURRED. (E	nter noture of injury in F	Part 1 or Por	t II of item 18 }			
MEDICA1	Hour o, m.	Month, Doy, Yes	While	NJURY OCCURRED Not while t ot work	20e. PLACE factory	OF INJURY (Home, form, street, office bldg., etc.	20f. (City	or town)	(Co	ounty}	(State)
			_		h 27	10 ES D	21				-1 1 1
1 2	. I certify the	or I attended the	deceasi	ed tram <u>""Plati"C</u> Po	11.21	_, 19.58, to_D	لبلب م 23	19_50 ،و	t_,that I ic	ast saw	the deceased
ali	ive on Dec	<u> </u>	, 19	$\Sigma \Omega_{-,-}$, and that	death oc	curred at 5.230				e date s	
1	M	n ma		lang on.	D		,	Ireal, city or town,			DATE SIGNED
Sig	TUAL / /	2111111		1 170	0, M.D.	Henryt	on Sta	ate Hospi	tal		12-11:-58
PHY	YSICIAN'S EC	lgars M. Ma	cula	ns, M. D.		Henryt	on, Ma	aryland			
	JR-AL, CREMATION MOVAL (Specify)	12.19 S	7	The NAME OF CEME	10 -	EMATORY Joans	22d. LOCA	TION (City, town,	or county)	1.	(Stote)
23 FUN	vary		ell.	MODRESS	llo.	240 REC'S	9 BY REGIST		STRAR'S SIGN		

moy be retained by the haspital ar attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in poge 3 should detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and the registrar part to burial, cremation, ar remayal, and in any event within 72 hours after death. VS A15 (4) 15M 9/5S

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. Page 4,



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. Page 4

TO FUNERAL DIFFE page 3 shauld

VS A15 (4) 15M 9/SII

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13588 **CERTIFICATE OF DEATH** Reg. Dist. No. 1357.)

1.	PLACE OF DEATH				- 11	USUAL RESIDENCE (W	here decease	d lived. If instituti		• before	admission)		
L	Carroll			MARY	AND	Maryland Allegany							
	b. CITY OR TOWN (I	f outside corporate limi earest fown)	ts, write	c. LENGTH OF STAY	N 1b	c CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town)							
L	Sykesvil	le.				Westernoo	ort		- (014	f 1. 2		
Г	d. NÄME OF HOSPIT OR INSTITUTION	AL (If nat in hospital, g	ive street	oddress)		d STREET ADDRESS				0.	IS RESIDENCE ON A FARM?		
		eld State F	lospi	tal							YES- NO		
3.	NAME OF DECEASED	Fir	st	Middle		Lou	4. DATE OF	Mon	th	Day	Yeor		
	(Type or print)	Harry		Eugen	e	Kooken	DEATH	Decem	her 3		19 58		
5.	\$EX	6. COLOR OR RACE	7. MARI	HED- NEVER MARRIE	0 🔲 B. C	ATE OF BIRTH		9. AGE (In years	IF UNDER		UNDER 24 HPS.		
	Male	White	WIDOWI	DIVORCED	0 6	/23/03		lost birthday) 55 yrs.	Months	Days 1	Hours Min.		
10	o. USUAL OCCUPATIO	ON (Give kind of work	done 10b.	KIND OF BUSINESS OF	RINDUSTRY	11. BIRTHPLACE (Stole	e or foreign c	ountry)	12. CITI	ZEN OF	WHAT COUNTRY		
l .	outing most of water	ring tire, even it retired]	Tlash					,	T C .	A T		
녆	FATHER'S NAME	Grane Opr.		-UNIVE	- 11	Maryland Mother's Maiden				J.S.	14.		
"	. I THINK S THOUSE				1								
<u> </u>	Warren K					Ethel C.	Snyder						
ΙŞ	. WAS DECEASED EVE	R IN U. S. ARMED FOR (If yes, give mor or dotes of s	CES7 16.	SOCIAL SECURITY NO.	17. INFO	RMANT		Add	ress				
L	no	-		-UMR	Sp	ringfield S	State I	Hospital	Record	ls			
Г	18. CAUSE OF DEA	ATH [Enter only one co	use per li	ne for (o), (b), and (c).]						INTERV	VAL BETWEEN		
	PART I. DEA	TH WAS CAUSED BY:	Act	te thrombo	sis o	f the left	100			1	nutes		
	453	DUE TO									HIMIOS		
	Conditions, if o	ny which)	Por	ger's Dise						770	0.396		
	gave rise to i	mmediale f		Ret. P DIRE	488					ye	ars.		
	couse (o), stoting	the under-	,										
lz	lying couse lost.) {c		Chitalanian Canaca	711 0117 - 10	7 601 4 700 700 7110 700 1				1			
CERTIFICATION				ONTRIBUTING TO DEA			MINAL DISEAS	E CONDITION GIV	EN IN PART	1(0) 19.	PERFORMED?		
٥	Schizop	nrenia reac	tion	, other and	unsp	ecified				Y	ES NO 🔯		
F	200. ACCIDENT WA	S UNDERLYING CONTROL CAUSE OF DEATH MEDICAL EXAMINER)	20b DES	CRIBE HOW INJURY OF	CURRED. (inter nature of injury in	Port I or Por	t II of item 18.)					
		MEDICAL EXAMINER)											
MEDICAL	20c. TIME OF INJUR	Y Month, Doy, Yes			20e. PLACE	OF INJURY (Home, for	m. 20f (City	or tawn)	{C	ounty)	(Stote)		
밁	Hour a.m.	19	While at war	Not while	· rectory	r, street, affice bldg , et	c.)						
1		at I attached the				_, 19 <u>.55</u> , to	12/3	10 58					
	alive on12	at I attended the	deceas	ed from2/_E		. 0314	50		_,that I to	ast saw	the deceased		
	alive onL&	12176	, 19	, and that	death oc	curred at 911				e date			
	ACTUAL CO.		Doll	n h				Ireel, city or town,	•		DATE SIGNED		
	SIGNATURE PC	noun	uev	CARRAGE	M D	Springfi	eld St	ate Hospi	<u>ital</u>	_12/	3/59		
	PHYSICIAN'S	metan dalo	- mm - a	W.D.		C1 3 3	2. 14	7 7					
	NAME (Type)	ustin delC	ampo,	M.D.		Sykesvil	le, Ma	ryland					
22		N. 226. DATE THEREC)F	22c. NAME OF CHIE	TENY OR G	MARTORY	22d LOC#	TION (Gify town,	ar county)		(Stote)		
	REMOVAL (Specify)	12-10	-58	7.411	Mb		11/	March	4 ft.	m	11		
23	FUNERAL DIRECTOR	S SIGNATURE	,	ADDRESS /		1 . / 240 REC	D BY REGIST	RAR 246 REG	STRAR'S SIG	NATURE	7		
	Weedler.	Уписал.	Thomas	1. Tioil	was 9	Tel Nan		-=-	The s		1.6		



VS A15 (4) 15M 10/57

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13589 CERTIFICATE OF DEATH

13580

20003				Keg.	Dist. No.	
1. PLACE OF DEATH O. COUNTY Carroll	WARYLAND 2.	USUAL RESIDENCE (When o. STATE Mary		COHNTY -	idence before admission Frederick	1)
	stay in 16 nos •12day			iils, wrile RURAL o	and give nearest tawn)	
d. NAME OF HOSPITAL (If not in hospital, give street oddress) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS Not	ne		e. IS RESIDE ON A FA YES N	ARM?
	Niddle PWS.	Lipps:	4. DATE OF DEATH	Month December	Doy Yeo 23, 19	58 58
	ORCED _ A	April 4, 1880) 1%	B yrs. IF UN	DER 1 YEAR 15 UNDER 2	24 HRS Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if refired) Housewife	ESS OR INDUSTRY	Maryland	foreign country)	12.	U.S.A.	YATMUC
13. FATHER'S NAME Charles Andrews	1	4. MOTHER'S MAIDEN NA Emma Klise				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURIT		rmant ringfield Hos	spital R	Address 9 COP d B		
1B. CAUSE OF DEATH [Enter only one couse per line for (o), (b), one PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO		neart diseas)		INTERVAL BETWOODSET AND DE	EATH
	ed arteri	iosclerosis			Years.	
C.B. 3. assoc. with district the tabol brain disease with psychotic real contributing of the cape of t	action.		•		PART I(o) 19. WAS AUT PERFORM YES N	
	RY OCCURRED. (E	inter noture of injury in Po	rt I or Parl II of i	lem 18.)		
20c. TIME OF INJURY Month, Doy, Year Not While Not while of work of work	foctory	OF INJURY (Home, form, , street, office bldg., etc.)				(Stote)
21. I certify that I attended the deceased from Fel alive an December 22, 1958, and ACTUAL SIGNATURE	that death ac	curred at 7:00A	M, from the DORESS (Street, cit	causes and ar	n the date stated	abave signer
PHYSICIAN'S Edmund Lusthaus, M.D.		Sykesville	, Maryla	nd		
DE NECOTAL / Space for	CEMETERY OF CR			ity, town, or count k, Maryl		-
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS M. R. Etchison & Son, Frederick,	Maryland	d 240. REC'D DEC	BY REGISTRAR 2 9 158	24b. REGISTRAR'S	SIGNATURE S. Hours	



	MAKTLAND STATE DEPARTMENT OF HEALTH—BALTIMOKE, 18
L	13530 CERTIFICATE OF DEATH Reg. Dist. No. 13581
2	. PLACE OF DEATH o. COUNTY O. STATE MARYLAND 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland D. COUNTY O. STATE Maryland Maryland O. STATE
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) HAMPSEAD. C. LENGTH OF STAY IN 1b C CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAMPSEAD.
	d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2.2 N. MAIN St. 1 d. STREET ADDRESS ON A FARM? YES NO PL
	NAME OF First Middle Last C.DATE Month Day Year OF DECEASED (Type or print) MAMIE GRAY LIPPY DEATH December 20 1958
	SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED S. DATE OF BIRTH 8. DATE OF BIRTH 9. AGE (In years lef UNDER 1 YEAR IF UNDER 24 HRS. lost birthday) WIDOWED DIVORCED DIVORCED DIVORCED STORY 100. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY) 11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT COUNTRY?
	HOUSE WILE HOME 14. MOTHER'S NAME US.A.
1	Francis Lucas HANN GARY Trice S. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 INFORMANT Yes, no. or unknown) It yes, give wor or dates of service) 218-34-0453 MYS Helen Lippy Gariett. Hamps FAD Mid
	PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Conditions, if ony, which gove rise to immediate cause (b) Lying cause lost. INTERVAL BETWEEN ONSET AND DEATH ONSET AND DEATH DUE TO Lying cause lost.
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY PERFORMED? YES NO 20s. ACCIDENT WAS UNDERLYING CAUSE OF DEATH III EITHER, NOTIFY MEDICAL EXAMINER!
1	
1	20c. TIME OF INJURY Month, Day, Year Hour o. m. 20d. INJURY OCCURRED While Not while of work o
	21. I certify that I attended the deceased from Dec., 1954, to Dec. 20, 1965, that I last saw the deceased alive on December 19, and that death accurred at 5,204 M, from the causes and an the date stated above. ADDRESS (Street, city or town, stote) DATE SIGNED
	PHYSICIAN'S JOSEPH E. BUSH MD HAMPS FEAD Md
2	22d BUDYAL CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OF CREMATORY 22d JOCATION (City. 10wm, or county) (\$100) 12-22-1958 Halefatera Cellicel Re) Med 1
2	2 FUNERAL DIRECTOR'S SIGNATURE ADDRESS 240. REC'D BY REGISTRAR'S SIGNATURE DATE DEC 2 2 2 2 2

i d. 70.04.6



executed within 24 hours ofter death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



			M					ENT OF HE			IMORE, 1	8			0.0
EN)	3. 1	LACE OF DEATH		<u> </u>	359	Z CER	TIFICA	TE OF DE			loved. If institute	Reg. Di		35	
~/		C. COUNTY	ARROLL			м	ARYLAND		aryl		b. COUNTY	How		OGHIISSII,	mj
	١	RURAL and give	(If autside corp negrest town) Sykesv		is, write	c. LENGTH OF S				side corpore	ate timits, write RI	URAL and	give heare	est town)	
15		or institution Springs	ield St	ate	ive street d Hospi	tal		d. STREET ADD		in St	reet	,		IS REST	FARM?
		NAME OF DECEASED Type or print)	Hary	Fir	n Rose		hrod	tost MADEN		4. DATE OF DEATH	Man Decer		Day 3		ear 9 58
	5. 5	ex 'emale	6. COLOR G		7. MARR	IED NEVER MA	RCED T) - 2º -70		5	AGE (In years last highlady)	IF UNDER			
Specially Sec.			ION (Give kind rking life, even	of work	ione 10b.			TRY 11. BIRTHPLAC	_	foreign cou			IZEN OF		COUNTRY
1	13.	Charles	Schrod					14. MOTHER'S MA	AIDEN NA	ME	?				
	1S. FYes	WAS DECEASEDEV		MED FOR	ervice)	SOCIAL SECURITY		S.H. rec			Addr		. Nd.		
		18. CAUSE OF DE PART I. DE 33/× Conditions, if	ATH WAS CAU IMMEDIATE	ISED BY: CAUSE (o) DUE TO	Cer	ebral he	morrha	ge drome ass		+ ad - =			INTER	VAL BETT	ays
		gove rise to couse (a), stating lying couse last	immediate the the the the the the the the the t	(b) DUE TO	,	onic bra	ru shii	arome ass	<u>ocra</u>	tea w	_	rosis	_	<u>Year</u>	5_
0	CERTIFICATION		e brain	SVD	drone	associa	ted wi	NOT RELATED TO THE thank arterial (Enter nature of In	oscl	erosi	with p		tid '	WAS AI PERFOR	MED?
	WEDICAL	20c. TIME OF INJU Hour o. m.	RY Month,	Day, Yea	While	Not while	20e. PLA foc	CE OF INJURY IHon ory, street, office bl	ne, form, dg., elc.)	20f (City o	or town)	(0	County)		(State)
/			hat I attend	led the	decease	d from Jan	uary 2	9, 19.57_, 10 occurred at 4	:25P	M, fram ODRESS (Sire	the causes a set, city or town, ate Hosp:	nd on ti	last saw	stated	deceased above signed
		NAME (Type)	Ilse K		N. D						yland				
	7	BURIAL, CREMATIC BEMOVAL (Specify	12-	8-5	8	THE NAME OF C	EMETERY OF	draf		130	LIGHTON, O	-	me	(State)	
	13	UNERAL DIRECTOR	A. John	rish	4	ADDRESS	rille.	//	a REC'D	BY REGISTR	^	TRAK'S SIC		4	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Rea, Dist. Na.

b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) e. IS RESIDENCE ON A FARM? YES NO Month Day Year 1958 AGE (In years lost birthdoy) IF UNDER 1 YEAR IF UNDER 24 HRS Months Doys 12. CITIZEN OF WHAT COUNTRY? WesTMINISTER PA INTERVAL BETWEEN ONSET AND DEATH CARCINOMA METASTATIC 8 MO. DE RIGHT BREAST PERFORMED? YES NO NO (County) (Stote)

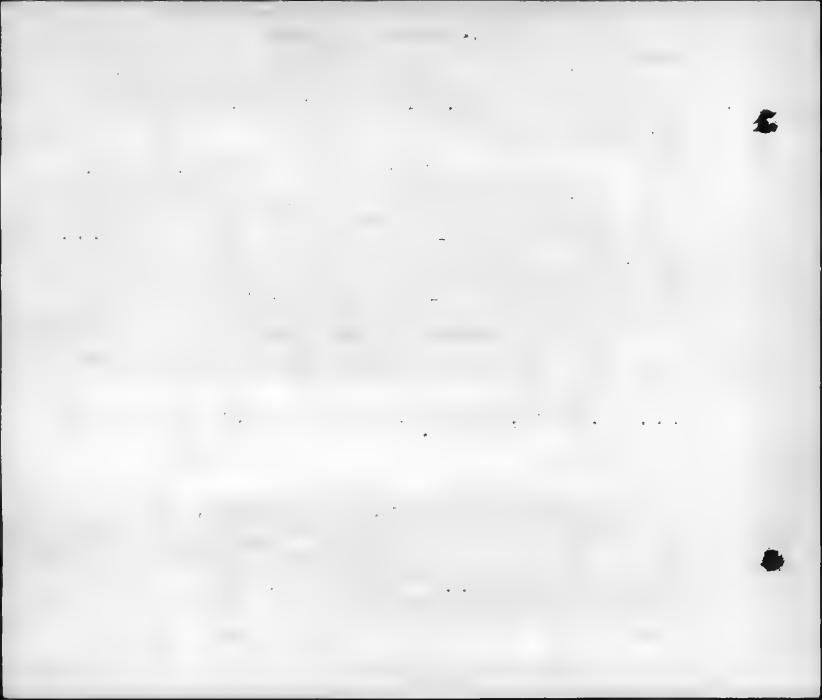
> ADDRESS (Street, city or town, state) DATE SIGNED

(State) 246. REGISTRAR'S SIGNATURE



hours ofter deoth.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18



VS A1S (4) 15M 9/5S 10.2°

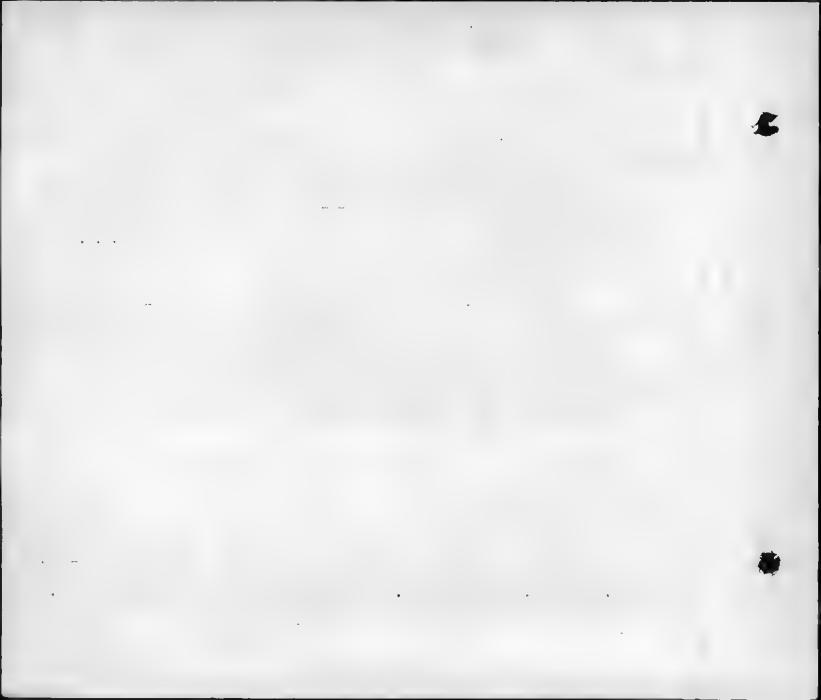
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13585

13595 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH							b. COUNTY			-		
b. CITY OR TOWN (IF		ts. write	c. LENGTH OF STAY IN		Mary		prote limits, write P	Prince				
RURAL and give ne	orest town)		913 days		Laurel /64/. 2							
d. NAME OF HOSPITA OR INSTITUTION		ive street			d. STREET ADDRESS e. IS RESIDENCE ON A FARM?							
OR INSTITUTION	Henryton S	tate	Hospital			616 10th Street						
3. NAME OF DECEASED	Fir	18	Middle		Lost	4. DATE	Mon	th	Doy	Year		
(Type or print)	Joseph		Alphonz		Nicholson	OF DEATH	Dece	ember	28	1958		
5. SEX	6. COLOR OR RACE	7. MARR	IED T NEVER MARRIED		B. DATE OF BIRTH		9. AGE (In years			INDER 24 HRS.		
Male	Negro	WIDOWE	DIVORCED		2-3-1910		lost birthday) 218 yrs.	Monns	Jays na	Urs Min.		
10a. USUAL OCCUPATIO	N (Give kind of working life, even if retired	dane 10b	KIND OF BUSINESS OR	INDUS	TRY 11, BIRTHPLACE (Stat	e or foreign o	country)	12. CITIZ	EN OF W	HAT COUNTRY?		
None					Laure	1, Mar	yland	U	.S.A.			
13. FATHER'S NAME					14 MOTHER'S MAIDEN	NAME						
Abral	ham Nichol	son			Laura	Hebur	n					
15 WAS DECEASED EVER	IN U. S. ARMED FOR		SOCIAL SECURITY NO.	17. II	HORMANT		Add	ress				
No	,,,,	7	05-07-7572		Joseph Alph	onza N	icholson	- Pa	tient			
PART I. DEAT O O A X Conditions, if or gave rise to in couse (a), staling I lying couse last	Conditions, if ony, which gave rise to immediate couse (a), staling the under DUE TO											
S 240X	ER SIGNIFICANT CON	IDITIONS <u>C</u>	ONTRIBUTING TO DEAT	H SUI	NOT KECATED TO THE TERM	MINAL DISEAS	SE CONDITION GIV	EN IN PARE	PE	REFORMED?		
TO THE EITHER, NOTIFY	S UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER)	20b. DES	CRIBE HOW INJURY OCC	CURRED	(Enter nature of injury in	Parl I ar Pa	rt II of item 18)					
20c, TIME OF INJURY Haur a. m. p. m.	/ Month, Day, Ye	While	NJURY OCCURRED 2 Not while at wark	Oe PLA	CE OF INJURY (Hame, far tary, street, affice bldg., et	m, 20f. (Cit	y ar tawn)	(Co	ounty)	(State)		
	at I attended the ember 28	, 12	58 , and that d	leath	, 19.56, to accurred at 6:15	A_M, fro	er 2819 58 m the causes of street, city or town, con, Mary	and on the	e date s	tated abave. DATE SIGNED 2—28—58		
PHYSICIAN'S Dr.	. Edgars M	Mac	ulans, Supt	•	Henryton	State	Hospital,	Henr	yton,	Md.		
220 BURIAL, CREMATION REMOVAL (Specify) 23. FUNERAL DIRECTOR	S SIGNATURE	<u>//578</u>	ADDRESS	ERY O	Chapel	22d LOCA	Marghan Mariney are necessarily and the second	or county) Lively STRAR: 5751GI	l.a	(Stote) Orcf		
1 00 (12)	1 140	RE	5 /1/U-		DAGE							



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 13588 13596 **CERTIFICATE OF DEATH** Rea. Dist. No director, iled with haurs after death. Page 1 PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased fixed. If institution Residence before admission) a. COUNTY filed b. COUNTY MARYLAND Carrol Maryland b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If guiside corporate limits, write RURAL and give negrest town) RURAL and give nearest lown) m 21 days Svkesville Baltimore 18.Md. d NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION d. STREET ADDRESS IS RESIDENCE ON A FARM? YES NO T Springfie d State Hospital 709 Beltian Avenue .5 3. NAME OF Middle 4. DATE Manth Year filled in (Type or print) DEATH W. Pomarina 150 B DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS S. SEX 6. COLOR OR RACE 7. MARRIED TI NEVER MARRIED T lost birthdoy) Months Dovs M DIVORCED | 10-7-71 WIDOWED IN popers. 100 USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR INDUSTRY 11, BIRTHPLACE (Stole or foreign country) 12. CITIZEN OF WHAT COUNTRY? deoth. during most of working life, even if retired) Lithographer U.S.A. New York puo that the death certificate be after 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME Philip Pomarius Johanna 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 INFORMANT Address S.S Hosital Records unkn unkn 18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c)] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Bronchopneumonia davs IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate **DUE TO** couse (a), stating the underlying couse last PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY C.B.S. assoc. with cerebral arterioscier. With Arterioscierotic cardiovasc disease. Uninary infection
Arterioscierotic cardiovasc disease. Uninary infection
Accident was underlying [] [20b. DESCRIBE HOW INJURY OCCURRED (Enter notive of injury in Port I or Port II of item IB.) cerebral arterioscler, with psych, reaction PERFORMED? YES TO NO 52 200 ACCIDENT WAS UNDERLYING TO OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, 20e. PLACE OF INJURY (Home, form, 20f (City or town) Day, Year 20d. INJURY OCCURRED (County) (State) factory, street, office bldg., etc.) Hour p. m. While Nat while at work □ 21. I certify that I attended the deceased from 7-22-, 1958, ta 12-12-1958, that I last saw the deceased __, and that death accurred at 5:304 M, from the causes and an the date stated above. alive an ADDRESS (Street, city or lown, state) DATE SIGNED Springfield State Hospital RAL DI . E the registror NAME (Type) Sykaswilla Maryland ന 22a. BURIAL CREMATION. 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (State) Poge REMOVAL (Specify) Mt. Olivet Cemetery Baltimore Maryland Burial 16.1958 Dec. O 23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS 240 REC'D BY REGISTRAR 24b REGISTRAR'S SIGNATURE Chilman S. Mences VS A15 (4) William Cook.Inc. 1217 St. Paul Street DATE 15M 10/57



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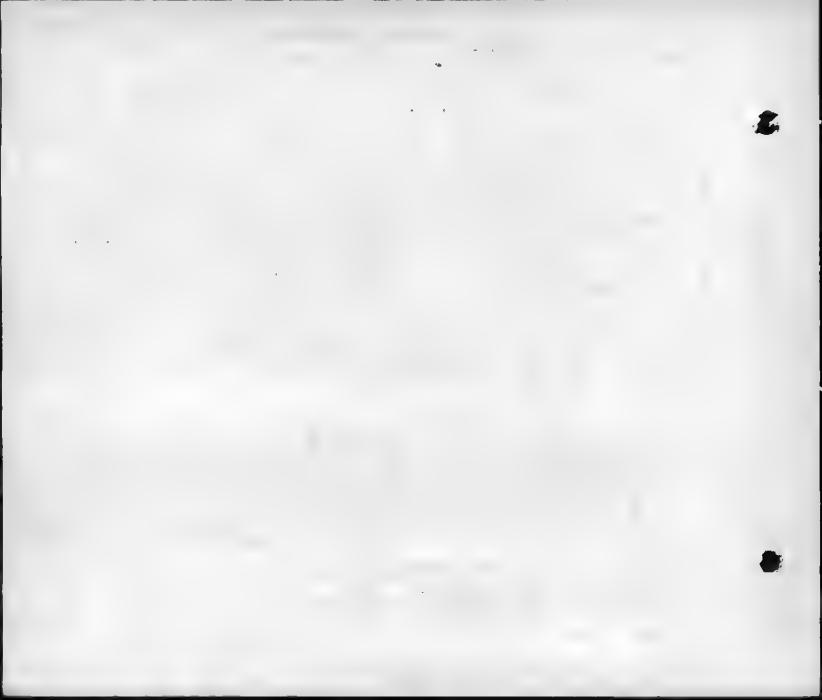
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH Reg. Dist. No. 12589

		17		IL OI DEA			Reg. Dist.	No.	
	PLACE OF DEATH			2. USUAL RESIDENCE (Where deceas	ed lived. If institution	on: Residence	before odmi	ssion)
	o. COUNTY Carroll	MARYLA	UND	Maryla	nd	b. COUNTY	Carr	oll	
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN	1 1b	c CITY OR TOWN (vn)				
	Sykesville	ly.5m.13d.		Sykes	ville				
	d. NAME OF HOSPITAL (If not in hospital, give street in	oddress)		d STREET ADDRESS					SIDENCE
	Springfield State Hosp	ital		/					A FARM?
	NAME OF First DECEASED	Middle		Lost	4. DATE	Mant	_	Doy	Year
	(Type or print) HERSCHE	L		REED	OF DEATH	н Decen	mber 2		19 58
5	Male 6. COLOR OR RACE 7 MARR			5-7-83		lost birthday)	Months D	YEAR IF UNI	-
20.	11.501.5					() yrs.			
190	usual occupation (Give kind of work done 10b during most of working life, even if retired)	KIND OF BUSINESS OR	PINDUST	RY 11. BIRTHPLACE (SIG		country)		en of wha U.S.A.	T COUNTRY?
13.	FATHER'S NAME	100 . 15. 16.		14 MOTHER'S MAIDEN			-!		
	John Reed			Marw I	Clizab	eth Harris	2		
15.	WAS DECEASEDEVER IN U. S. ARMED FORCES? 16	SOCIAL SECURITY NO	17. INI	FORMANT	- A. L. D. C. V.	Addr		_	
[Yo	s. no or unknown) (If yes, give wor or dates of service)	Unite.	Rec	cords, Sprin	ngfield	d State Ho	ospital	1	
-	18 CAUSE OF DEATH [Enter only one couse per lin	e for (a), (b), and (c).]						INTERVAL E	SETWEEN
	PART I. DEATH WAS CAUSED BY ATT	eriosclerot	ic o	cardi ovascui	lar dis	92292		Vear	
	4-22 / DUE TO			JG: 42014504.	40.4	20400			<u>. </u>
	Conditions if you will be	Generalized	art	teriosclero	kis			Year	8
	gave rise to immediate (
	lying couse last.								
Z	PART II OTHER SIGNIFICANT CONDITIONS C							(o) 19. WAS	AUTOPSY
ZYI	Chronic brain syndrome a	ssociated w	ith,	circulator	dist	irbance, w	rith		ORMED?
TIFIC	Chronic brain syndrome a cerebral arteriosciprosi 200 ACCIDENT WAS UNDERLYING [] 20b DESC	RIBE HOW INJURY OCC	URRED	(Enter nature of injury	n Port I of Po	et II of Hem 18)	071a		
CERTIFICATION	200 ACCIDENT WAS UNDERLYING 206 DESC OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	11							
CAL		JURY OCCURRED 2	De PLAC	CE OF INJURY (Home, fo	ırm, 20f. (Ci	ty or town)	{Co	unty)	(State)
MEDICAL	Hour o. m. While at work	Not while	Focto	ory, street, office bldg.,	otc.)				
2	7.00	Trans.	19	2057	Decembe	er 2, 19 58			
	21. I certify that I attended the decease ative on December 2 195	ed Homes		accurred at 8:)	A	19.20	2,that I la	st saw the	e deceased
	alive on December 2 , 195	ond that d	leath (accurred at 9.43		Im the causes a Street, city or town,			ted abave. DATE SIGNED
	ACTUAL COMMITTED DE	O Camb.	B	C.		•			DATE SIGNED
	SIGNATURE COUNTY OF	1 4000	M	D	oringi	<u>ield State</u>	, nosp	rrat	
	NAME (Type) Agustin del Cam	po, M. D.		S	ykes vi	lle, Maryl	Land		,
220	BURIAL CREMATION, 226. DATE THEREOF	22c. NAME OF CEMET	ERY OR	CREMATORY	224 100	ATION (City towns o	or county)	(Sto	ate)
7	MEMOVAL (Specify) 17-5-58	That The	ico	مسر	Little	a Store	walk L	3. 7	Siell,
23.	FUNERAL DIRECTOR'S SIGNATURE	ADDRESS C	M	14. RE 240. RE	C'D SY REGIS		STRAR'S SIGN	IATURE	-
1	tuttur It. Italger (pykiacil	Khino	THE DATE	DEC 8	58	No A A	15 mg	

VS A15 (4) 15M 9/SS

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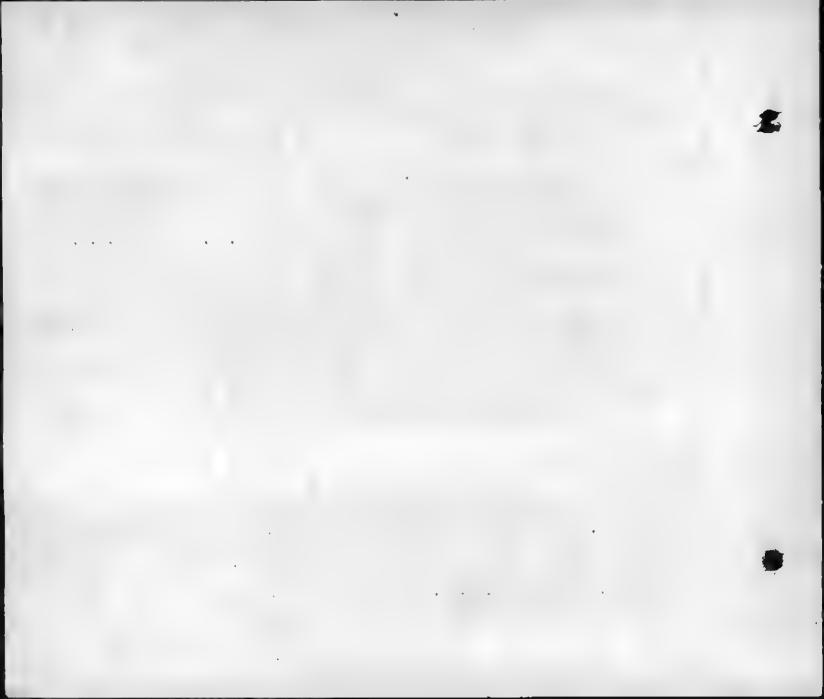


P00e		lirector	ed yair	
IO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. Page		TO FUNERAL DIFFOOR: After this certificate has been signed by the ottending physician and completely filled in by # _ Luneral director	page 3 should, letached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 d be filed with	
ffer d		No Aun	PI	
aurs a		n by	and 2	•
1 24 h		illed i	es 1 o	
withir		etely f	Pog	
culed		omple	apers.	J.h.
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PHYS	ol ar	this ce	r use o	emoti
DING	haspit	After	red fa	iol, c
THE	y the	TOR	letac	to bu
O NO	ined b	DIP	P	prior
PITAL	e retoi	RAL	shoul	istror
HOS	may be retained by the haspital ar attending physician.	FUN	oge 3	he reg
9		0		-

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 13598 CERTIFICATE OF DEATH

13590

										Keg. Dit	I. No.	(4
1, PLACE OF DEATH					2. USUAL RESI	DENCE (WI	ere decease		f Institutio	on: Residenc	e befare o	dmission)
Carroll				YLAND		Mary.					ltime	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				IN 1b	c CfTY OR 1	OWN (If a	utside corpo	prote limit	s, write RI	URAL and gi	ive nearest	tawn}
Henryton, M	<u>aryla</u>	nd	922 day	s		Dund	alk		05[19 PC		
d. NAME OF HOSPITAL (If not in OR INSTITUTION			•		d. STREET A	DORESS				,	e. 15	S RESIDENCE
Henryt	on St	ate	Hospital			303 !	lomp <u>k</u> :	ins	Cour	t	YE	ES NO 🖫
3. NAME OF DECEASED	First		Middle		Los	t	4. DATE OF		Mon	h	Day	Yeor
(Type or print)		seph N.			Ric	e	DOLLARIA -		ecember		29 19 58	
S. SEX 6. COLOR	OR RACE	7 MARR	IED T NEVER MARRI	ED B	DATE OF BIRT	Н		9. AGE	In years	IF UNDER	Days H	UNDER 24 HRS.
Male Negr	V	WIDOW			March 3	0, 19	918	4	O yrs			
10a. USUAL OCCUPATION (Give kind during most of working life, ever	d of work do n if retired)	one 10b.	KIND OF BUSINESS C	OR INDUST						12. CITI	ZEN OF W	VHAT COUNTR
Laborer			Unknow	7n.			ld, S	. C.			U.S.	A.
13. FATHER'S NAME					14. MOTHER'S	MAIDEN	JAME					
	y Ric					trice	e Col	eman				
15. WAS DECEASED EVER IN U. S. Al (Yes, no. or unknown) {If yes, gave wor	RMED FORG or dates of ser	VICE			FORMANT				Addr	ess		
No			18-07-355		Joseph	N. R:	ice -	Pat	ient			
18. CAUSE OF DEATH [Enter o											INTERVA	AL BETWEEN
PART I. DEATH WAS CAI	CAUSE (o)	Fa	r advance	d bi	ilateral cavitary tuberculosis							
10000	DUE TO											
Conditions, if any, which a	(b)_											
cause (a), stating the under-	DUE TO											
lying couse last.	(c)_											
PART II. OTHER SIGNIFIC	ANT COND	HTIONS C	ONTRIBUTING TO DE	ATH BUT N	IOT RELATED TO	THE TERMI	NAL DISEAS	E CONDI	TION GIV	EN IN PART		WAS AUTOPSY ERFORMED?
\ <u>\{\}</u>											YE	S NO
Part II. OTHER SIGNIFIC	NG [] 2 OF DEATH AMINER]	706. DESC	CRIBE HOW INJURY C	CCURRED.	(Enter noture o	finjury in f	Part I or Par	t II of iter	n 18.)			
20c. TIME OF INJURY Month, Hour o. m.	Doy, Year		JURY OCCURRED	20e. PLAC	E OF INJURY (Home, form	20f. (City	or lown)		(C	ounly)	(State)
₩ p, m,	19	While of work	Nat while	1000	ory, milest, drines	bidg., etc	1					
21. I certify that I atten	ded the d	decease	ed from Jun	e_20	19 56	to De	cembe	er 20	919 58	Sthat I le	ast saw	the decease
alive on Dec. 2	9	. 12.5	8, and that	deoth	occurred at	1:20	A.M. from	n the c	guses o	nd an th	e date :	stated abov
9 h			*				ADDRESS (S				o duit s	DATE SIGNE
ACTUAL 14 117,	Mes	rla	en Mi,	7. M	.D.	Hen	cyton	Mai	rylai	nd	12	2-29-58
PHYSICIAN'S								*	- triffie vir da m. vo			
NAME (Type) E. M.	Macu	lans	, M. D.		Н	enry	ton St	tate	Hos	pital		
220- BURIAL, CREMATION 22b. DA	TE THEREOF	~	22c. NAME OF CEM	ETERY OR	CREMATORY		22d JOCK	TION (CI	y, toyth, o	r county	10	(Stole)
1/	7/8	7	ame	Car	L. I		101	ul	les	X	10	
23. FUNERAL DIRECTOR'S SIGNATUR	Ė	111	ADDRESS	10-	1111	24a. REC'				TRAR'S SIG		
Holland tu	neral	Ho	me 6631h	mures	HO Be	DATERI	2 '59	}	Cirth	47 7 3	L'all	



VS A15 (4) 1SM 9/55

13599 CERTIFICATE OF DEATH

1.001	3.5			•		Reg. Dist.	No.			
1. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, If Institution: Residence before								sion)		
o. COUNTY Carroll	MARYLAN	4D	Maryland	Monte	comery					
b. CITY OR TOWN (If outside carporate limits, write c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside carporate limits, write RURAL and give neares) town)							
RURAL and give nearest town) Sykesville		Takoma Park								
d NAME OF HOSPITAL (If not in haspital, give street of OR INSTITUTION	6 days		d. STREET ADDRESS				e IS RE	SIDENCE A FARM?		
Springfield State Hos	pital		Carroll	Avenu	ıe			NO [X]		
3 NAME OF First	Middle	**********	last	4. DATE	Mont	h	Day	Year		
(Type or print) HELEN	VERDE		ROSS	OF DEATH	Decer	mber 1	.1	1958		
S. SEX 6. COLOR OR RACE 7. MARRI	ED NEVER MARRIED	X) 8	DATE, OF BIRTH	£	9. AGE [In years	IF UNDER I	YEAR IF UND	ER 24 HRS.		
Female White WIDOWE		_ 1	Nov. 12, 18	72	last birthday)	Months D	Pays Hours	Min.		
100. USUAL OCCUPATION (Give kind of work done 10b	KIND OF BUSINESS OR II	VDUSTI	Y 11 BIRTHPLACE (Slote	or foreign c	oungry)	12. CITIZ	EN OF WHA	COUNTRY		
during most of warking life, even if refired) Proof Reader	HTELT Class	u.		0	two		U.S.A			
13. FATHER'S NAME			14 MOTHER'S MAIDEN N	IAME						
Thomas Ross			Helen							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16 (Yes, no. or unknown) [(II yes, give war or dotat of service)	OCIAL SECURITY NO.	7 INF	ORMANT		Addr	B35				
No No		Re	cords, Sprin	ngfiel	d State !	Hosmit	al			
18. CAUSE OF DEATH [Enter only one cause per lin	e far (a), (b) and (c)						INTERVAL B	ETWEEN		
PART I. DEATH WAS CAUSED BY:	ute renal in	enf	ficienav			ONSET AND DEATH Davs				
604X DUE TO										
Conditions if you which \	Many which I I winner transf infantion							Days		
gove rise to immediate Quir TO	immediate Quit To									
cours (o), soling the under-										
7 (6	ONTRIBUTING TO DEATH	BUT N	OT RELATED TO THE TERMI	NAL DISEAS	E CONDITION GIVE	N IN PART	LPART 1(a) 19 WAS AUTOPSY			
Acute brain syndrome associated with metabolic disturbance (uremia)						PERF	ORMED?			
Diabetes mellitus 200. ACCIDENT WAS UNDERLYING [] 20b. DESC	RIBE HOW INJURY OCCL	IRRED	(Enter nature of injury in I	Part Lar Par	t II of item 18)		163 [_	NO CO		
UP CONTRIBUTING CLAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										
						(Co	unty)	(State)		
20c. TIME OF INJURY Month, Day. Year 20d. IN Haur a. m. While at work	Nat while	facta	ry, street, office bldg , etc.	1			•			
21. I certify that I attended the decease	D	ם יין מ	1958, to Dec	rember	17 10 58	24		1		
olive on December 11										
olive on processings and	, and that de	orn o	ccurred ot4:00 1		n The Causes a Treet, city or town, s			ed obove. ATE SIGNED		
ACTUAL POSSESTE SEC	Campao	ı		,		'				
SIGNATURE CEPTURATION CCC	NATURAL CAMPAS M.D. Springfield State Hospital 12-11-58									
PHYSICIAN'S Agustin del Camo	0 1		Syltest	ville,	Maryland]				
220 BURIAL, CREMATION, 226. DATE THEREOF	22c. NAME OF CEMETER	Y OR	CREMATORY	22d LOCA	TION IC ty, lawn, a	r county)	(510			
Bremoval Isocity Dec 12, 1958	GEORGE WA	SHIN	IGTON CEM	K1665	Kd. AVAT	TSVILL	5, 1	nd		
23 SEPHERAL PHRECTOR'S SHEWATHINE	ADDRESS WA	SH.	12, DC 240 REC	D BY REGIST	TRAR 245 REGIS	TRAR'S SIGN				
Das	4 Garroll	St	NW . DATE .	E 1E0	-1 -8	0 1				



VS A15 (4) 1SM 10/57

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sclor, with	6

H

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13500 CERTIFICATE OF DEATH

13592

-		Reg. Dist. No.						
Î	PLACE OF DEATH COUNTY Carroll MARYLAND	2 USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland b. COUNTY						
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give mearest town) SURESVILLE	c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town) Baltimore 3 Val-4						
	d. NAME OF HOSPITAL (IF not in haspital, give street address) OR INSTITUTION Mae Pullen Nursing Hime	d. STREET ADDRESS 2900 Southern Avenue 6. IS RESIDENCE ON A FARM? YES NO X						
3	3 NAME OF DECEASED (Type or print) Emma Middle	Schere OF DEATH December 22nd 19 58						
	temale white WIDOWED DIVORCED []	Jeb. 22, 1883 9 AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min Min Months Days Hours Min Min						
1	100 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TOUSEWLTE	11. BIRTHPLACE (Stole or foreign country) 12 CITIZEN OF WHAT COUNTRY: Germany Germany						
1	13 FATHERS NAME Frederick Bugge	14 MOTHER'S MAIDEN NAME						
	Dies, no. no uninness) . Ill see com mor or dieter of seconds.	Address 15. Ella Wortham, 2400 Southern Ave.						
	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gove rise to immediate couse (a), stoting the under: lying couse lost.	bral bemanglique. 1437 bral bemanglique. 22 per 58						
10012100	COATI	NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 19. WAS AUTOPSY PERFORMED? YES NO						
ш		(Enter nature of injury in Part I or Port II of dem 18.)						
400000	20c TIME OF INJURY Manth, Day, Year Hour e m. 19 While Not while of work of twork of twork of two the control of two	CE OF INJURY (Home, form, 20f (City or town) (County) (State) ary, street, affice bldg., etc.)						
	21. I certify that I attended the deceased from							
	PHYSICIAN'S Howard E. Hall	D. A GULLET						
	220 BURIAL CREMATION, 226 DATE THEREOF 22c. NAME OF CEMETERY OR DUTIAL 12/24/58 Loudon Par	crematory 22d. 10cation (City. town, or county) (Stole) rk Cem. Baltimore, Maruland						
2.	1 FUNERAL DIRECTOR'S SIGNATURE ADDRESS Leonard J. Ruck 5305 Hartord Road	4 #141 240 REC'D BY REGISTRAR 246 REGISTRAR'S SIGNATURE						

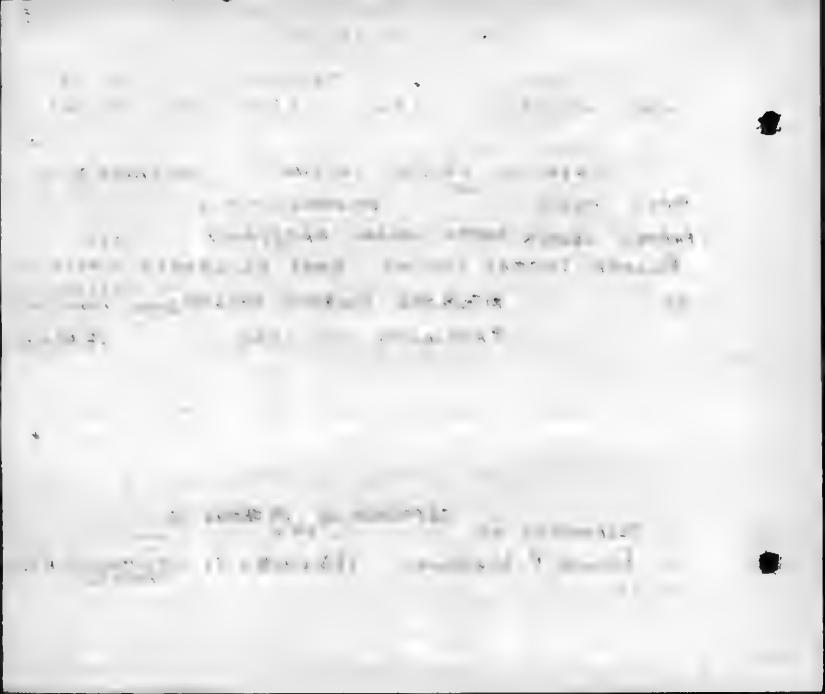


		1	3601	CERTIFI	CAT	E OF DEATH	ł		Reg. D	ist. No		0011
	PLACE OF DEATH				2	USUAL RESIDENCE (Wh	ere decease	ed lived. If institution	oni Reside	nce befo	re odmis	sion)
	· COUNTY	arroll		MARYLAN	- 11	• STATE Marvla	_	6 COUNTY	-	_	eorge	,
	b. CITY OR TOWN (IF	outside corporate limi	ls, write c.	LENGTH OF STAY IN	ь	c. CITY OR TOWN (If o	7 7 10 10 10	orote limits, write R				
	RURAL and give ne	lle (Rural)	25	3 v. 8 m. F	,		cnown		1			· V
	d. NAME OF HOSPITA	AL (If not in hospital, g	ive street addr) (II.	d STREET ADDRESS	LILOWII		7.		e. 15 RES	SIDENCE
	OR INSTITUTION	ield State								- 1	ON A	FARM?
7	NAME OF	fir		Middle			nown					
(Type or print)		**		midule 1 /		Last	OF DEATH	Month				Year
	SEX	6. COLOR OR RACE	<u> </u>	NEVER MARRIED	7 0 0	Sessums ATE OF BIRTH	DEATH	9. AGE (In years	nder If under	12		1958
-				_			.7	lost birthday)	Months	Days	Hours	Min
	Female	White	MIDOMED [-	Tune 16, 189		67 yrs	110 0	*****]
100	during most of works	ing life, even if relired	DOING TOD KITAL	D OF BUSINESS OR IN	NUUSIKT			country	112. CI			COUNTRY
	HOUSEWI FATHER'S NAME	16			l.	Virgi				U	A.	
EJ.		Th 2 0 00 00				MOTHER'S MAIDEN N	IAME					
_		Edwin H. R					Mary	r Boyd				
15. {Ya	s, no or unknown) (I	IN U. S ARMED FOR	CES? 16, SOC	IAL SECURITY NO	7 INFO	RMANT		Add	T015.			
	No				Sp	ringfield 3	tate	Hospital	Reco	rd		
		TH [Enter only one co	use per line fo	r (o), (b), and (c)]		0 /				INTI	ERVAL BE	TWEEN
		TH WAS CAUSED BY: IMMEDIATE CAUSE (a)	100	YONAH	/	Scler	2515			1	1)6	-CK'S
	4.20,1	DUE TO		/								
	Conditions, if an			LOCATO	10.	10090	1/010	TICN			Vo	0 1-0
	gave rise to in cause (a), stating the	mediate (/							/		
	lying cause lost.) (c)	50	NILE	(00	LNOI-ENO	15 1	(Corra)	TICAL		100	a VS
Ö	PAIN II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS ANTOPSY											
CERTIFICATION	Psychosis with Mental Deficiency YES NO D											
ME	20g ACCIDENT WAS UNDERLYING TO 20b. DESCRIBE HOW INJURY OCCURRED (Faler nature of injury in Part Lor Part III of item 18.)											
	OR CONTRIBUTING CAUSE OF DEATH-											
MEDICAL	20c. TIME OF INJURY	Month, Doy, Yes	r 20d. INJUR	Y OCCURRED 20e	PLACE	OF INJURY IHome, farm	20f. (Cit	y or town)	(County)		(Slote)
WED	Hour o.m.	19	White at work	Not while at work	ractory.	street, office bldg., etc	1					
	21. I certify that I attended the deceased from November 18 1958, to December 12, 1958, that I last saw the deceased											
	alive on Decel			ram1 <u>toyento</u>	324	7) 1430 ° 10566	GHACT	<u>+</u> , 1920_	_,that I	last so	aw the	decease
	alive authara	noer de	7 19.20.	and that de	ath ac	curred at \$30_8		m the causes a itreet, city or town,		he da		ed abave ATE SIGNEI
	ACTUAL	Mexit	19 1	Viben							7.0	ATE SIGNE
	SIGNATURE 7	, roge corjus) R	12000	M.D.	Springfic	<u> </u>	Rate Hospi	<u>tta.</u>		12	77577
	PHYSICIAN'S KO	nstantin W	shor li	I. D.		Sykesvill	a Na	See free				
22-												
420	BURIAL CREMATION	17-15-1	1950 2	. NAME OF CEMETER	CR CR	EMATORY C	ZZd. LOCA	TION ICITY Town, o	or county)		(Stat	2 /
22	FUNERAL DIRECTOR'S	SIGNATURE	138	ADDRESS	inc	our semel	my 1	maden	slow	19	YY	Ld.
23.	I P A / A	The state of the s	0	P = 4	1	240. REC'T	BY REGIS	TRAR 245, REGIS				
7	11:14.00	omuses	6. /	Min 6 At	1/2	May DATE EC	1 1 3	(-1 2.	rade	to the second	

TO HOSPITAL OR VS A15 (4) 15M 9/55



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18



e. IS RESIDENCE ON A FARM?

IF UNDER 1 YEAR IF UNDER 24 HRS. Days

U.S.A.

12. CITIZEN OF WHAT COUNTRY?

INTERVAL BETWEEN ONSET AND DEATH

PERFORMED?

YES NO 🕞

(Stote)

DATE SIGNED

(Stote)

vears

YES NO T

Yeor

19 58

Reg. Dist. No

Montgomery

5. SEX

hours ofter death. Page

13605 CERTIFICATE OF DEATH 1. PLACE OF DEATH o. COUNTY 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) **b.** COUNTY MARYLAND Marvland Garroll b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town) RURAL and give nearest town! Svkesville lvr. 8mo. 11days Chevy Chase d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION d. STREET ADDRESS Springfield State Hospital 5300 Saratoga Ave. NAME OF DECEASED 4. DATE Middle Month (Type or print) DEATH Elizabeth Shoemaker December Ruth 6. COLOR OR RACE 7. MARRIED NEVER MARRIED TO 8. DATE OF BIRTH 9. AGE (In years lost birthday) DIVORCED | WIDOWED [12/12/93 Female 100 USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS, OR INDUSTRY 111, BIRTHPLACE (State or foreign country) during most of working life, even if retired Maryland Government Work 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME Sarah Perry William Shoemaker 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT 274-30-0444 Springfield Hospital Records 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] PART I. DEATH WAS CAUSED BY: Arteriosclerotic cardiovascular disease IMMEDIATE CAUSE (o) **DUE TO** Conditions, if ony, which gove rise to immediate **DUE TO** cause (a), stating the under-

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(9) 19, WAS AUTOPSY C.B.S. assoc, with circulatory disturbance with psychotic reaction. 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part 1 or Part II of item 18.) OR CONTRIBUTING | CAUSE OF DEATH

> 20d. INJURY OCCURRED Not while of work of work

20e PLACE OF INJURY (Home, form. 20f (City or lown) factory, street, office bldg., etc.)

(County)

19 58 that I last saw the deceased

or county)

21. I certify that I attended the deceased from.___

PHYSICIAN'S NAME (Type)

220 BURIAL CREMATION.

REMOVAL (Specify)

lying couse lost.

, and that death accurred at 5:158 M, from the causes and on the date stated above.

Edmund Lusthaus.

22c. NAME OF CEMETERY OR GREMATOR

M.D. Springfield State Hospital Sykesville. Maryland

ADDRESS (Street, city or town, stote)

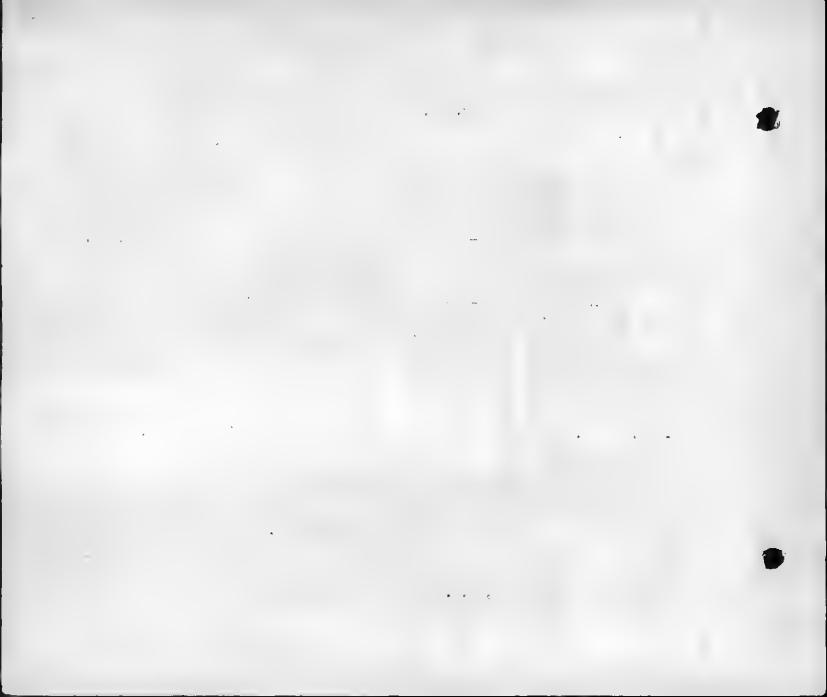
Y	228 LOCATION	4 (City, to
	4/1-	12 -1

240 REC'D BY REGISTRAR 245 REGISTRAR'S SIGNATURE

23. FUNERAL DIRECTOR'S SIGNATURE

20c. TIME OF INJURY Month.

Hour e.m.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 13597 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Reg. Dist. No. EALTH DEPT I. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. COUNTY b. COUNTY Files. Health, MARYLAND b. CITY OR JOWN II outside c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 Sond a vergeorest town) Les than Ida d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address). d STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NO NAME OF 4. DATE DECEASED OF DEATH (Type or print) 7. MARRIED NEVER MARRIED | 8 DATE OF BIRTH 9. AGE [In years IF UNDER TYEAR Months WIDOWED | 10g. USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (Stote or fore.gn country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) Solesman pages 33. FATHER'S NAME File 16. SOCIAL SECURITY NO 18. CAUSE OF DEATH | Enter only one cause per line for INTERVAL BETWEEN PART I, DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate cause DUE TO (o), stoting the underlying cours fost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION. GIVEN IN PART 1(0) 19. WAS AUTOPS PERFORMED? Brein Syndrowe, on Lo 20d. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CAUSE OF DEATH. 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of Item 18.) 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 1 20f. (City or town) 20r. TIME OF INJURY Month, Doy, Year (County) (Stote): factory, street, office bldg., etc.) Hour o.m. Not while of work of work 2) I certify that I tack charge of the remains described above, held on Autopsy . Inspection ... Inquiry . and in my opinion death resulted from: Natural causes . Accident ... Suicide . Homicide . Undetermined manner DATE SIGNED ACTUAL CHIEF MEDICAL EXAMINER SIGNATURE ASSISTANT MEDICAL EXAMINER [7] EXAMINER'S DEPUTY MEDICAL EXAMINER | NAME (Type) 220. BURIAL CREMATION, 226 DATE THEREOF 22c NAME OF CEMETERY OR CREMATORY 22d, LOCATION (City, fown, or county) (Stote) REMOVAL (Specify) 23. FUNERAL DIRECTOR'S SIGNATURE 240 REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE A15ME DATEDEC 5M 2/57





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ong per md i			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY:	INTERVAL BETWEEN
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Office SI-tro			Conditions, if ony, which) (b) Utrican Track Julestion	7
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Me Me		CERT	200. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING A CAUSE OF DEATH. 20b DESCRIBE HOW INSURY OCCURRED (Enter nature of injury in Port I or Port II of Hom 18) Tell from Chart	
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Page			21. I certify that I taak charge of the remains described above, held an Autopsy [], Inspection [], Inquir	y . and in my
ote, ote, 10kg			apinian depth resulted fram: Natural causes Accident [], Suicide [], Hamicide [], Undetermined s	nonner 🔲
S S S			SIGNATURE ALLES J. MOREN M.D. CHIEF MEDICAL EXAMINER	DATE SIGNED
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desi	YUN		EXAMINER'S JAMES J MARSH DEPUTY MEDICAL EXAMINER S	1-38
short riss		270	BUYDAL, CREMATION 726 DATE THEREOF 220 PARTIE OF CEMETERY OR CREMATORY 220 DOCATION GLU- TOWN, OF COUNTY)	(State)
5 , 45 ,		23	FUNTERAL DIRECTOR'S SIGNATURE / ADDRESS / TO 1740 MEC'D BY REGISTRAR'S SIGNATURE	MATURE
VS. A15ME 5M 2/57	1/1		Durael Fumeral, Home. 3/03/9/alls Weak DEC 1 0 '58 C	-
			Horse F. Dinget	aletare



13599 CERTIFICATE OF DEATH 13607 Rea. Dist. No. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. COUNTY 5 COUNTY Balto.Gitv MARYLAND Maryland Carroll death. c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b CITY OR TOWN (If outside corporale limits, write Sykesville 21vrs.9mos.20days Baltimore e. IS RESIDENCE d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS Springfield State Hospital 90h Prestwood Rd. YES TO NO DO 2 NAME OF Month Middle Sylvester Stockbridge December 58 10 (Type or print) 9. AGE (In years lost birthdoy)
53 yrs 6. COLOR OR RACE 7 MARRIED T NEVER MARRIED T B. DATE OF BIRTH IF UNDER I YEAR IF UNDER 24 HRS. S. SEX Male Whi.te July 7. 1905 DIVORCED | WIDOWED | 10a. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stote or foreign country) during most of working life, even if retired) 12. CITIZEN OF WHAT COUNTRY? ě U.S.A. Maryland 14 MOTHER'S MAIDEN NAME 13 FATHER'S NAME Jason W. Stockbridge Cora Bowersock 17 INFORMANT 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 116. SOCIAL SECURITY NO. Address Springfield Hospital Records No INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c)] ONSET AND DEATH PART I. DEATH WAS CAUSED BY Arteriosclerotic heart disease Years IMMEDIATE CAUSE (o) 400,0 DUE TO Generalized arteriosclerosis Years Conditions, if ony, which gove rise to immediate **DUE TO** couse (a), stating the underlying couse lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 PERFORMED? Schizophrenia, paranoid type. YES TO NO TO 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18) 20e. PLACE OF INJURY (Home, form, 20f. (City or town) 20c TIME OF INJURY Month. Doy, Year 20d INJURY OCCURRED (County) (Stote) foctory, street, office bldg., etc.) While Not while of work 0.05 1955 to December 22, 1958 that I last saw the deceased 21. I certify that I attended the deceased from March 7. 58, and that death occurred at 12:55AM, from the causes and an the date stated above. ADDRESS (Street, city or town, stote) DATE SIGNED Springfield State Hospital ACTUAL SIGNATURE 3 should TO FUNERAL PHYSICIAN'S Agustin delCampo. M.D. Sykesville, Maryland NAME (Type 270. BURIAL, CREMATION, 22b. DATE THEREOF 22d LOCATION (City, town, or county) 22c. NAME OF CEMETERY OR CREMATORY (Slote) ADDRESS 246 REGISTRAR'S SIGNATURE 23. FUNERAL DIRECTOR'S SIGNATURE C' I'M & Thank DATE DEC 2 3 '58 VS A15 (4)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



22c+ NAME OF CEMETERY-OR-CREMATORY

or Wed. Vie

Springfield Hospital

Sykesville, Maryland.

24g REC'D BY REGISTRAR

22d. LOCATION (City, tawn, or county)

Balternore, Mel

246 REGISTRAR'S SIGNATURE

WA I Frank

DATE SIGNED

attending physician and CTOR FUNERAL D

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VS A15 (4) 15M 9/55 Agustin delCampo.

22a. BURIAL, CREMATION, 22b. DATE THEREOF

REMOVAL (Specify)



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

director,

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hours ofter death. Page



hours ofter death. Page



13611 CERTIFICATE OF DEATH

13602 Reg. Dist. No.

		20011	CENTIFICA	IL OF PLATE	Reg. Dis	it. No.
		LACE OF DEATH COUNTY (Larroll)	MARYLAND	2. USUAL RESIDENCE [Where deceded o. STATE	b. COUNTY	ce before admission)
A	1	CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. RURAL and Give nearest town) C. NAME OF HOSPITAL (If not in haspitol, give street and OR INSTITUTION)	LENGTH OF STAY IN 16	d. STREET ADDRESS	rporate fimits, write RURAL and s	give nearest tawn) e. IS RESIDENCE ON A FARM2
7		IAME OF FIRST FIRST FOREST	Middle	Lost 4. DAT	Q.L.	Day Year
	S. S	EX 6. COLOR OR RACE 7. MARRIED WIDOWED [DATE OF BIRTH	9. AGE (in years IF UNDER lost birthday) Months	19-5 1 YEAR IF UNDER 24 HRS. Days Hours Min.
	10a	USUAL OCCUPATION (Give kind of work dane 10b. KIN during most of working life, even if retired)		RY 11. BIRTHPLACE (State or foreig	1/4/	IZEN OF WHAT COUNTRY?
	13.	TATHER'S NAME		14. MOTHER'S MAIDEN NAME	/	
		Jacob Masin		TIMA	_	
	TS / (You	NAS DECEASEDEVER IN U. S ARMED TORCES? 16. SOI	CIAL SECURITY NO 17. IN	FORMANT Wilson	Address Address	ille mol.
		18. CAUSE OF DEATH [Enter only one cause per line f	or (a), (b), and (c).]	/	7	INTERVAL BETWEEN
		PART I, DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) CI		2 days		
		OUE TO				
		Conditions, if any, which) (b) H	PERTENSIVE C	ARDIOVASCULAR DIS	IBASE	10 years
		gove rise to immediate cause (a), stating the under- lying cause lost.	TABETES MELLI	rus		15 years
7	CERTIFICATION	PART II. OTHER SIGNIFICANT CONDITIONS CON	TRIBUTING TO DEATH BUT N	NOT RELATED TO THE TERMINAL DISE	ASE CONDITION GIVEN IN PAR	
		20g ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	E HOW INJURY OCCURRED.	. (Enter noture of injury in Part 1 ar	Part II of item 18.)	
	MEDICAL	20c. TIME OF INJURY Month, Day, Year 20d, INJU While of work	_ Not white fact	CE OF INJURY (Home, form, 20f. (1 ary, street, affice bldg., etc.)	lity or town) (C	County) (State)
		21. I certify that I attended the deceased alive an 25 December 1258		, 19, to26 Dece accurred at 12:02AM, fr	mber , 19 58 that I I	last saw the deceased he date stated above.
		ACTUAL SIGNATURE)		(Street, city or town, stote) ad at Eldershur	DATE SIGNED
1		PHYSICIAN'S Wm. H. Lawson, C			, Maryland	***************************************
		211111 12 29-58	2c. NAME OF CEMETERY OR	Venerial Farder	CATION (City town, or county)	arroll Ex. mil
	23.	FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	DATE AN 5	6	
		recreece The 11166 1661	- House	CUITAGE ONIE THE	59 Cithur 8 s	Marina.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 haurs after death. Page 4 may be retained by the haspital or allending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the ottending physician and completely filled in by the funeral director, page 3 should:

Aloched for use as the buriof-transit permit. Then please remove carban papers. Pages 1 and 2 and by the filled with the registrar prior to buriof, cremation, or remaval, and in any event within 72 hours after death. 134 VS AIS (4) 15M 9/SS



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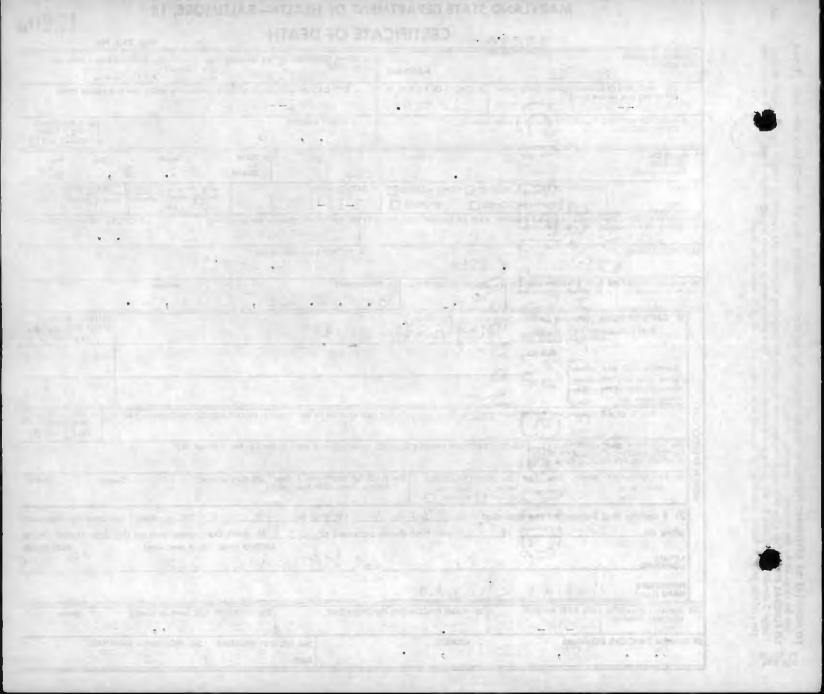
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	1.3	613	CERT	IFICA	ATE OF D	DEATH			Reg. D	ist, No.		0000
1. PLACE OF DEATH 0. COUNTY	Carroll	V-E-A	MAI	RYLAND	2. USUAL RESI	DENCE (Whe		lived. If instit b. COUN		ence befor		sion)
RURAL and give n	orest town) Westminst		c. LENGTH OF STA					ate limits, write	RURAL and	-	arest fowr	n)
d. NAME OF HOSPI OR INSTITUTION	TAL (If not in haspital, ç	jive street (address)		d. STREET A	2.5	6	**			a. IS RES	SIDENCE A FARM?
3. NAME OF DECEASED (Type or print)	PAUL	'sł	M .		ILE	at	4. DATE OF DEATH	DEC	ionth	LO,	ıγ	Yeor 1958
s. sex male	white	WIDOWE		ED []	3-15-	1903			Months	R 1 YEAR Days	IF UNDI Hours	ER 24 HRS. Min.
	ON (Give kind of work king life, even if retired Laborer	done 10b.	farming			rylan	_	untry)		J.S.		COUNTRY?
13. FATHER'S NAME	William	D.	Zile		14. MOTHER'S Mar		Lov	ell				
15. WAS DECEASED EVE (Yex, no. or unknown)	R IN U. S. ARMED FOR (If yes, give wor or dates of s	CES? 16.	SOCIAL SECURITY N	10.73	F. A	. Zil	e, G		ddress , Md			
Conditions, if a gave rise to i couse (a), stating lying cause lost.	mmediate Duran)	Nephri	lis_	acul		IAL DISEASE	CONDITION	GIVEN IN PA	ONS	9. WAS	DEATH2
O HE BITHER, NOTIFY	AS UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER)		CRIBE HOW INJURY		. (Enter noture of					(5		NO E
20c. TIME OF INJUR Hour o. st. p. m.	19	While at work	Not while	foci	ary, street, office	e blog., etc.)	201. (City	or rownj		(County)		(State)
21. I certify that I attended the deceased from Y, 19 49, to Dec. 10, 19 5 that I last saw the deceased alive on Dec. 10, 19 5 that I last saw the deceased alive on Dec. 19 5												
220. BURIAL, CREMATIC REMOVAL (Specify) BURTAT, 23. FUNERAL DIRECTOR	12-13-1	958	ADDRECE	METERY OR	CREMATORY		Carr		De, M			
ZJ. FUNERAL DIRECTOR	Waltz.	Wind	riela. M	d.		24o. REC'D			GISTRAR'S SI	GNATUR	E	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 haurs after death. Page 4 may be retained by the haspital or attending physician.

TO FUNERAL DIFFCEOR. After this certificate has been signed by the attending physician and completely filled in by to page 3 shauld tetached for use as the burial-transit permit. Then please_remaye carbon papers. Pages 1 and 2 the registrar prior to burial, cremation, ar remayal, and in any event withly 72 hours, after death. VS A15 (4) 15M 9/55



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18